OMB CIRCULAR A-76—CONTRACTING-OUT IN VA FACILITIES

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

NINETY-SEVENTH CONGRESS

FIRST SESSION

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CONTENTS

OCTOBER 20, 1981

	Page
OMB Circular A-76—Contracting-Out in VA Facilities	1

STATEMENTS BY COMMITTEE MEMBERS

Statement of Chairman Montgomery	1
Statement of Hon. John Paul Hammerschmidt	3
Statement of Hon. Marvin Leath	15
Statement of Hon. Daniel A. Mica	86

WITNESSES

Harkin, Hon. Tom, a Representative in Congress from the State of Iowa	4
Prepared statement of Mr. Harkin	77
Sowle, Donald, Administrator, Office of Federal Procurement Policy, OMB, accompanied by Ms. Darlene Druyan, Deputy Associate Administrator	7
Prepared statement of Mr. Sowle	78
Smith, Hon. Virginia, a Representative in Congress from the State of Nebraska	28
Prepared statement of Mrs. Smith	86
Cook, Clyde C., Assistant Administrator for Supply Services, Veterans' Administration, accompanied by Dr. Donald L. Custis, Chief Medical Director, and Ms. Marjorie Quandt, Assistant Chief Medical Director for Administration	31
Prepared statement of Mr. Cook	87
Kershner, Mrs. Joan, Director, Veterans' Administration Medical Center, Columbia, S.C.	39
Kelleher, William H., Director, VA Medical Center, West Roxbury, Mass.	39
Harper, Dr. Morris, Chief Medical Officer, Outpatient Clinic, VA Medical Center, Baltimore, Md.	39
Green, Dr. Howard, Chief of Staff, VA Medical Center, White River Junction, Vt	39
Schmidt, Dr. Richard P., Chairman, Special Medical Advisory Group to the Veterans' Administration	47
Ryan, Dr. Richard M., disabled veterans' representative to the VA Special Medical Advisory Group	48
Gonzalez, Hon. Henry B., a Representative in Congress from the State of Texas	52
Prepared statement of Mr. Gonzales	91
Moody, Miss Yvonne, Director of Nursing, VA Medical Center, Minneapolis, Minn	54
McGuire, Ms. Mary Helen, Chief, Dietetic Service, VA Medical Center, Washington, D.C.	54
Prepared statement of Ms. McGuire	92
Cleveland, Jesse P., Chief, Building Management Service, VA Medical Center, Washington, D.C.	54
McBride, Neil, Chief, Engineering Service, VA Medical Center, Cleveland, Ohio	54
Condino, Albert, Administrator, Our Lady of Victoria Hospital, Lackawanna, N.Y.	59
Prepared statement of Mr. Condino	95

Page

Mullennix, Gary, President, Huntington Laboratories, Inc., Huntington, N.Y... 59
Prepared statement of Mr. Mullennix 96
Gleason, Joseph D., executive vice president, American Federation of Government Employees 62
Prepared statement of Mr. Gleason in behalf of Mr. Kenneth Blaylock, president, AFGE 156
Pierce, Arte I., president, National Veterans' Administration Council, AFGE... 65
Prepared statement of Mr. Pierce 174
O'Dell, Ms. Virginia, president, Local 2547, AFGE, Iowa City, Iowa 67
Prepared statement of Ms. O'dell 178

MATERIAL SUBMITTED FOR THE RECORD

Memorandum: Memorandum of March 21, 1980 from the General Counsel of the Veterans' Administration to the Chief Medical Director regarding the opinion of the General Counsel on OMB Circular A-76 89
Statements:
Hefner, Hon. W. G. (Bill), a Representative in Congress from the State of North Carolina 276
Daub, Hon. Hal, a Representative in Congress from the State of Nebraska..
Kastenmeier, Hon. Robert W., a Representative in Congress from the State of Wisconsin 278
Rose, Hon. Charles, a Representative in Congress from the State of North Carolina 280
Zablocki, Hon. Clement J., a Representative in Congress from the State of Wisconsin 279
Joeckel, Charles E., Jr., deputy national legislative director, Disabled American Veterans 281
Sweeney, John J., president, Committee on Political Education, Service Employees International Union 283
Lyman, Stanley Q., executive vice president, National Association of Government Employees 283
VA schedule of cost reviews; Department of Veterans Benefits 82
Written committee questions and answers:
Hon. G. V. Montgomery to Veterans' Administration 287
Hon. G. V. Montgomery to OMB 287

OMB CIRCULAR A-76—CONTRACTING-OUT IN VA FACILITIES

TUESDAY, OCTOBER 20, 1981

HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The committee met, pursuant to notice, at 8:30 a.m., in room 334, Cannon House Office Building, Hon. G. V. "Sonny" Montgomery (chairman of the committee) presiding.

Present: Representatives Montgomery, Edwards, Mottl, Edgar, Hall, Applegate, Leath, Boner, Shelby, Mica, Daschle, Stump, Murphy, Dorgan, Hammerschmidt, Heckler, Sawyer, Solomon, Jeffries, McEwen, Dunn, Smith of Alabama, and Siljander.

OPENING STATEMENT OF CHAIRMAN G. V. "SONNY" MONTGOMERY

The CHAIRMAN. Good morning, the committee will come to order. We are meeting this morning to continue oversight hearings into the Veterans' Administration's implementation of Office of Management and Budget Circular A-76, "Policies for Acquiring Commercial or Industrial Products and Services Needed by the Government."

As you know, the Subcommittee on Oversight and Investigations held a hearing on this subject last July. During that hearing, witnesses from the VA, OMB, American Federation of Government Employees, and the veterans' organizations presented testimony. A retired VA hospital director also presented his views on contracting.

Serious charges and questions were raised about the circular's impact upon the VA's ability to deliver quality health care and the price for delivering that care. It was determined during that hearing that OMB is requiring VA to conduct A-76 cost comparison studies of three indirect patient care functions of the Department of Medicine and Surgery. These are hospital food preparation, hospital custodial services, and hospital plant maintenance. The VA has testified that the review of the three functions will involve about 1,460 studies nationwide at a cost of approximately $10 million.

Concerns have also been expressed about the treatment of the VA employees who stand to be affected by the circular's implementation. Should OMB Circular A-76 be fully implemented, approximately 22,800 VA employees stand to lose their jobs. It should be noted that 64 percent or 15,592 of these employees are veterans.

It was also learned during the subcommittee hearing that, contrary to what the committee had been led to believe, OMB is possibly considering the contracting out of direct health care. The OMB witness had stated during questioning at the hearing that OMB was considering only the three indirect patient care services. However, in response to written questions posed subsequent to the hearing, OMB replied that such health care functions as surgical, medical, dental, psychiatric care, hospitalization, outpatient, and nursing care, et cetera are considered as examples of commercial or industrial services under Circular A–76.

As a result of that hearing, it was determined that a full committee hearing should be scheduled in order that all members might have an opportunity to hear what the impact on the quality of health care delivered in VA hospitals might be if these services are provided by contractors rather than the present VA staff. I am sure most of you have received correspondence from concerned veterans in your districts as to the damaging impact of A–76 on hospital care, hospital management, and VA employees. We have scheduled a wide selection of expert witnesses today, and I'm certain they will enlighten us as to the impact of Circular A–76 upon the Veterans' Administration.

Our first witness this morning will be the Honorable Tom Harkin, who represents the Fifth Congressional District of the great State of Iowa. He will be followed by the Honorable Virginia Smith, the gentlelady from the Third District of Nebraska; Mr. Donald Sowle, Administrator of the Office of Federal Procurement Policy, OMB, and Mr. Clyde Cook, Assistant Deputy Administrator for Procurement and Supply of the Veterans' Administration. Dr. Donald L. Custis, Chief Medical Director, and Ms. Marjorie Quandt, Assistant Chief Medical Director for Administration, will accompany Mr. Cook.

Next will be a panel of VA hospital directors and chiefs of staff. They will be followed by a panel of VA employees who will be directly affected by A–76—the nursing service, dietetic service, building management service, and the engineering service. We look forward to questioning these witnesses because of their firsthand experiences with contracting out.

Our third panel consists of Mr. Albert Condino, administrator of our Lady of Victoria Hospital in Lackawanna, N.Y., and Mr. Gary Mullenni.:, president of Huntington Laboratories, Inc., in Huntington, Ind. They will be followed by Dr. Richard P. Schmidt, chairman of the Special Medical Advisory Group to the Veterans Administration and Dr. Richard M. Ryan, disabled veterans' representative to the special medical advisory group.

Our final panel of witnesses will consist of representatives of the American Federation of Government Employees.

Several Members of Congress have indicated they wish to submit statements for inclusion in the hearing record, as they were unable to join us this morning. Therefore, the record will be kept open for 5 days in order to allow interested individuals to submit such statements.

I would now like to recognize our very able ranking minority member, the Honorable John Paul Hammerschmidt of Arkansas for any remarks that he would like to make, and after Mr. Ham-

merschmidt I would like to recognize the ranking member on our side, Mr. Don Edwards, if he has anything to comment on.

Mr. Hammerschmidt.

STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

OMB Circular A-76 continues to be a matter of concern to the Members of Congress, and that concern certainly warrants this hearing by the full Committee on Veterans' Affairs. I congratulate you, Mr. Chairman, for scheduling it.

A provision in Public Law 97-66, which was just signed last Saturday by the President, prevents the Veterans' Administration from making costly A-76 studies of its medical program out of funds appropriated specifically for actual medical care. This action became necessary when the Congress became aware that some 4,000 such studies were being required at a cost of $29 million.

Mr. Chairman, it would have been harmful to the VA medical program to have had to absorb that amount of unbudgeted money. If these studies are really necessary, then in my view the VA should ask for appropriations for the specific purpose of making them.

There is really not very much new about the idea of contracting out for some governmental functions which are not inherently governmental in nature. But, Mr. Chairman, there is something new about what appears to be a greatly increased emphasis on the VA medical program in terms of contracting out. Such contracting possibilities need to be clearly considered in terms of making absolutely certain that quality of care is not compromised. In this connection, the interrelationships of activities involved in running a hospital or clinic are almost inseparable. This is particularly true of such things as food preparation and delivery and maintenance of absolute cleanliness of facilities.

Mr. Chairman, I am anxious to hear our witnesses this morning. They come from a broad spectrum of individuals who should be able to assist the committee in arriving at conclusions with respect to this important subject. I am delighted to note that we have two of our very distinguished colleagues who are going to testify this morning. I notice one of them is already here. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Hammerschmidt.

Mr. Don Edwards, the ranking member of this committee.

Mr. EDWARDS. I associate myself with your remarks, Mr. Chairman. Thank you very much.

The CHAIRMAN. Thank you.

I see our witness has arrived, Congressman Tom Harkin of Iowa. I knew Mr. Harkin would be pretty close to on time. He's an ex-naval aviator and he knows he has to be on time and on target. We are very glad to have you this morning to testify on this very important matter.

STATEMENT OF HON. TOM HARKIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Mr. HARKIN. Thank you, Mr. Chairman. When the "deck is opened," you have got to be there to catch the wire or else.

Thank you, Mr. Chairman, and members of the committee, for allowing me to testify on this issue of contracting out at VA hospitals.

Mr. Chairman, I have a written statement and I would ask permission that it be inserted in its entirety, and I will just comment on it.[1]

The CHAIRMAN. Without objection. The gentleman may proceed in any manner he wishes.

Mr. HARKIN. I know you have a lot of expert witnesses and I don't want to infringe too much on your time.

I would like to elaborate, Mr. Chairman, just on two points from my written statement. First, in keeping with what Congressman Hammerschmidt just said, I think that contracting out will make it more difficult to provide quality medical care to our Nation's veterans. I think it will be more difficult because dietary services, plant maintenance, and engineering functions are essential to the total operation of a medical center. Contracting these out, I think, will make them disjointed, leading to a decline in the quality of care.

The services provided by our VA hospital workers are not like serving food in a restaurant or cleaning ashtrays in an office building. VA hospital workers care for sick patients, many of whom have very special needs. Yet, instead of a meal prepared by dieticians at the hospital, our veterans can expect a frozen dinner heated in a microwave. That is not quality medical care in my opinion.

The second point I would like to make is that in some cases contracting out will impose tremendous economic hardships on our local communities and our small businesses there. For example, in Knoxville, Iowa, at our VA hospital, more than 300 workers may have their jobs contracted out. For many of these people, there is no other place to go for employment. Knoxville is a small town with only 8,000 residents, and the VA hospital is the major employer in that community.

Some of these workers may have the chance to continue on in their present jobs as employees of the contractor, but they would undoubtedly have to accept lower wages and benefits and lose their seniority. And since many of these workers are veterans, by contracting out the Government is indirectly reducing its mandated obligation to give employment preference to veterans. For example, at the Knoxville hospital of the 91 workers employed in building management, 60 are veterans. In engineering, 67 of the 93 workers are veterans. That is almost 70 percent in just those two divisions.

Now, proponents of contracting out suggest that this will save taxpayers' money and help small business. But I fail to see how bringing in frozen food from Chicago helps small grocery stores, butchers, and appliance dealers in Knoxville, Iowa.

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[1] See p. 77.

I question the long-term savings that may be projected from the foot-in-the-door, first year bids. Contractors can and, indeed, have in the past increased their prices dramatically after the in-house capability has been destroyed. So I think that contracting out will result in higher costs to the Government and a decline in services to our veterans. It disregards any impact on the local community. I think it is ridiculous to launch a nationwide program without testing to see the effects in these areas, and I urge that such a test be undertaken.

In the meantime, I would like this committee to consider legislation requiring VA hospitals to draw up an economic impact statement describing the effects on the community before any contract is let. This information will provide a more accurate assessment of the total cost of contracting out.

I am informed, for example, that in the Midwest, which would affect the Veterans Hospital in Knoxville, Iowa, contracts for food services will be let on a regional basis. Therefore, it is quite logical, and many people have assumed, that the successful bidder will be a major food supplier who supplies other institutions out of Chicago, Ill., and will probably pick up Iowa and some surrounding States.

Mr. Chairman, I would like to thank you for holding this hearing. I congratulate the members of this committee for taking a thorough look at the effects of contracting out at veterans hospitals, and again I hope a complete look will be taken at the economic impacts on the small communities and, as Congressman Hammerschmidt said, at the quality of care for our veterans who do, in fact, have special needs.

The CHAIRMAN. Thank you, Mr. Harkin.

I would like to say before posing questions to our witness that we do have a number of witnesses this morning. If we could be brief and to the point in our questions, and also if the witnesses would do likewise in their testimony, we might be able to complete this hearing by noon when the House convenes. The Chair will implement the 5-minute rule for each member and will call on the members in the order that they arrived at today's meeting.

The only thing the Chair would say, Mr. Harkin—and I appreciate your fine testimony—that in H.R. 3995 which the President has just signed and which you supported, there was a provision pertaining to A–76 and the effect it would have on the Veterans' Administration. The provision stated that the estimated $10 million to make the study could not be taken out of medical care accounts of the Veterans' Administration. Therefore, it would seem to us that the money will have to be appropriated before they can make these studies. It just didn't make sense to take these funds out of medical care funds when we're having enough problems funding the program as it is.

I thought you and the other members of the committee would like to be reminded that this has been done and it is a step forward in what we are trying to do.

Mr. Hammerschmidt?

Mr. HAMMERSCHMIDT. Excellent news, Mr. Chairman.

I want to thank our friend and colleague, Mr. Harkin, for bringing us this very meaningful testimony. I think it is pretty repre-

sentative of the concern we have heard from many of our colleagues in the form of letters or verbal expressions.

I don't have any questions, but we appreciate your being here, Tom.

The CHAIRMAN. The Chair will go down the list and call on each member, and then after this the Chair will recognize members who have comments.

Mr. Edwards?

Mr. EDWARDS. I have no questions, Mr. Chairman, but I thank our colleague for a fine statement.

The CHAIRMAN. Mr. Stump?

Mr. STUMP. No questions.

The CHAIRMAN. Mr. Leath of Texas?

Mr. LEATH. No questions.

The CHAIRMAN. Mr. Edgar?

Mr. EDGAR. Tom, I would like to thank you for coming this morning and indicate that when other witnesses come before us, particularly the VA and the administration, the concerns that you raise in your statement are going to be raised by at least this member and I think by many people here on the panel.

I think you focused on the right point when you talked about how many persons who work for the Veterans' Administration are veterans and how many of those will be displaced by this particular decision. I think we ought to quantify the number of persons who have served the country well and who now serve in the Veterans' Administration who will be impacted in a negative way by this decision. I think this hearing will make sure that we don't let this particular issue go unnoticed. Contracting out in this area has been tried before and it had not worked well in the past. I think there are some real questions as to whether or not contracting out these basic services will work at this point. I compliment you for your statement.

Mr. HARKIN. Thank you.

One thing you just brought to my mind—and I hope you will examine it with the witnesses that come before you—is this aspect: We are going to show, I assume, that by contracting out and getting rid of the retirement benefits and other benefits that accrue to these workers in the VA hospitals, contracting out will cost less because the company that comes in probably will not have the kind of retirement program that is set up now for the people in civil service.

But I think we ought to keep in mind that there are going to be changes made in the social security system in the coming 2 or 3 years. And what kind of an impact will that have? You see, if more and more funds out of social security will be shifted to general revenues, that will, in fact, cause the contractor to pay more into social security, thus increasing the cost. For the first 2 or 3 years contracting out may be cheaper, but after that it won't be cheaper at all. And then we'll have veterans who will have lost their jobs, as you pointed out.

Mr. EDGAR. Also your illustration points out the impact on the quality of care within the VA, and I think that should be underscored. Thank you.

The CHAIRMAN. Thank you, Mr. Edgar.

Mr. Applegate of Ohio?

Mr. APPLEGATE. I would just like to thank our colleague for his valuable testimony.

The CHAIRMAN. Mr. Dorgan?

Mr. DORGAN. No questions.

The CHAIRMAN. Mr. Solomon?

Mr. SOLOMON. No questions.

The CHAIRMAN. Mr. Murphy?

Mr. MURPHY. No, Mr. Chairman. I just want to thank Tom for his very excellent and well prepared statement.

The CHAIRMAN. Mr. Shelby?

Mr. SHELBY. No questions.

The CHAIRMAN. Thank you very much, Tom. We appreciate your being here and starting off these hearings with your fine testimony.

Mr. HARKIN. I thank the committee for looking into this.

The CHAIRMAN. Congresswoman Virginia Smith will be here in just a few minutes to testify.

Is Mr. Sowle from the Office of Management and Budget here? We're glad to have you, sir. You may come to the witness stand, and also introduce your associate. If you could summarize your statement, we would very much like to hear the testimony from the OMB.[1]

As I understand it, this circular did come from the Office of Management and Budget. We would like to have the reasoning for this, Mr. Sowle. You may proceed.

STATEMENT OF DONALD E. SOWLE, ADMINISTRATOR, OFFICE OF FEDERAL PROCUREMENT POLICY, OFFICE OF MANAGEMENT AND BUDGET, ACCOMPANIED BY DARLEEN DRUYUN, DEPUTY ASSOCIATE ADMINISTRATOR

Mr. SOWLE. Mr. Chairman, I have with me this morning Darleen Druyun, who is the Deputy Associate Administrator for the Office of Federal Procurement Policy. We are very pleased to be here this morning to continue the discussion that was started last July.

In conformance with your request, Mr. Chairman, I will brief my statement and try to bring out the most important aspects of that.

This morning I would like to begin this discussion with mentioning several issues that I think are very important to the statement that I have prepared and submitted to you. First of all, there are proven contract techniques the Veterans' Administration can use to insure qualified contractors are selected to perform support-type hospital services. There are three major areas that I will just mention, although they are discussed to some extent in my prepared statement.

First of all, in developing a statement of work, it is very important that these be done carefully so that the Government can acquire exactly what it needs to support the requirement.

Second, in selecting a qualified contractor, there is an obligation on the part of the contracting officer and the Government agency to actually see that the contractor is qualified and that there is competition for whatever work is to be performed under the contract.

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[1] The prepared statement of Mr. Sowle appears on p. 78.

Third, after the contract is awarded, there is a requirement that the contractor be evaluated for performance against the standards that were initially set up, and to insure that these requirements are met 100 percent in terms of what the Government has required in the contract itself.

The second issue I would like to say just a few words about is the application of the circular to the VA's mission of providing direct medical care to qualified veterans. This area I know is of vital concern to this committee and is very important to us in the Administration, that medical care to veterans is carried out in the best way and the most effective way possible.

The revised circular—which incidentally was initially set forth in 1955 and has been in existence ever since—was published in March 1979; that is, the revised part of it. This applies to all the Federal agencies, including the Veterans' Administration. There are several agencies in addition to the VA which as a part of their mission provide health services for the members of the agency.

The application of the circular to those activities is a determination by the agency head. In implementing the circular, agency heads examine such areas as existing statutes and individual functions to assure they are not inherently governmental, or otherwise precluded from being contracted.

In the case of the VA, their General Counsel, in an opinion dated March 21, 1980, concluded that contracting out direct patient care is precluded by law and therefore must be performed by Government personnel. However, their counsel also concluded that support activities not directly related to patient care are subject to the provisions of the circular. I would like to state that OMB supports this position.

The third issue that I have in my statement that I would like to discuss is the private sector's use of contract services in the health care arena. In the July 1981 periodical entitled "Modern Health Care," there is a rather enlightening article on the subject entitled "Contract Management Survey." The highlights of this article are fourfold.

First of all, some 4,079 hospital and health care facility departments were managed by outside contractors in 1980. Cost containment pressures are the primary factors for the use of contract services in clinical and nonclinical areas. The services most frequently contracted for are housekeeping, food service, respiratory therapy, plant operations and maintenance, pharmacy, laundry, and other miscellaneous services. And finally, the contracting out support services "allows a hospital to concentrate its energies on its main purpose—healing the sick."

We still support the judicious and proper application of the circular in the VA hospitals where such application would not adversely affect the excellent health care services currently offered by the VA.

We in OMB are very much concerned with the loss of management flexibility as a result of the language contained in section 601 of the bill entitled "Veterans' Disability Compensation, Housing and Memorial Benefits Amendments of 1981." As indicated by the President when he signed the bill, we will work with you, this committee and the VA to allay your concerns and find a mutually

agreeable approach to the proper application of the circular's provisions to the VA.

Mr. Chairman, with that concise statement, I would be pleased to try and answer any questions you may have.

The CHAIRMAN. Thank you very much, Mr. Sowle. I have several questions.

I am a little confused about some statements I have seen from private enterprises that might move in on this contracting out, whether A–76 is to contract out for the entire service or for employing someone to manage the VA staff. It seems to me the contracting firms, as I read their proposals, would just send in a management team to work with the VA personnel.

One of the problems we have in Government now is too many management teams, and not enough "Indians" doing the work. So it looks to me like you are talking about putting another layer on the VA.

Mr. SOWLE. No sir; I don't believe that is the case of Circular A–76 at all. The idea—in fact, I think it would be illegal to have a contractor come in and manage Government employees. So that when these services are contracted out, the contractor actually has his own employees and it manages its own employees, not the Government's employees.

The CHAIRMAN. Mr. Sowle, what would keep a contracting firm from getting a food and dietetic contract at a low-cost bid which was probably lower than the hospital was doing it with VA employees, and having this contract for 1 or 2 years and then raising the price? That has been the experience we have had in the military where we would contract out and then these contractors would come in and raise the prices, and eventually it would be more than what it cost the Government with the military doing it themselves.

Mr. SOWLE. The way this would be precluded, Mr. Chairman, is that the initial contract is under a competitive situation. The contractor would be obligated to offer option years. Now, this would carry you out 3 years or 5 years perhaps. At that time there could be a recompetition to assure that his prices were not just loaded up without justification or without changes in the economy that the competition would actually support.

In other words, there would be competition to preclude the incumbent contractor from raising his prices.

The CHAIRMAN. Competition with other contractors?

Mr. SOWLE. Yes, sir. This is normal procedure, to go back out on competition for work that is already done by service-type contractors.

Ms. DRUYUN. I would also like to state very clearly that the contractor, when he would initially submit his bid, would bid a firm, fixed price for the first year, and for the first option period and the second option period. There have been some recent reports from the Department of Defense, for instance, that address the very point that you raise with respect to whether or not contract prices are initially, in essence, a buy-in, and then later on raised by contractors. Some recent GAO reports, as well as some audit reports by the Department of Defense, clearly state that the savings they anticipated have been generally experienced throughout the life of the contract.

If a contracting officer is faced with a situation where a contractor, because of a change in the work statement, tries to arbitrarily raise his contract price at a contract option exercise period, you are free at that time—because it is an option that is strictly at the Government's desire whether or not they are going to exercise it—you can at that time recompete the requirements to come up with what you consider to be a fair and reasonable price.

There are also other factors built into the circular, such as within a 5-year period, for instance, you could conduct a new A–76 cost comparison study to insure that the function is still cost-effective as a contract operation, as opposed to being an in-house operation.

The CHAIRMAN. Thank you very much.

Most of us serve on other committees. On the Armed Services Committee we have found that the Department of Defense cannot get contractors to bid on certain jobs.

What if we do away with the work force in the dietetic field at the VA hospital in Los Angeles and we can't get anybody to bid out there, and we have let all our equipment run down—and after 2 or 3 years, it doesn't take long—and no employees, what happens to the food service at this VA hospital?

Ms. DRUYUN. I would like to state that the Department of Defense experience, in the support type services that we're talking about, is very favorable and has known that there is an awful lot of competition. Food service operations, for instance, within the Department of Defense for military facilities typically have anywhere from 5 to 20 bidders. This is even 10 years after the function was initially contracted out.

The CHAIRMAN. Don't you think you're going a little far when you contract out for chaplains under the proposal?

Ms. DRUYUN. That is a determination that has to be made by the agency head of the Veterans' Administration.

The CHAIRMAN. It came back in an OMB response that punchboard operators, laundry workers, and chaplains are included, as I remember it.

Mr. Sowle, you mentioned the provision we put into the legislation now signed by the President. Where will the funding come from? Will you instruct the Veterans' Administration not to use medical care funds to make these studies, as the law has directed?

Mr. SOWLE. I think at the present time, Mr. Chairman, as I am sure you are aware, the A–76 implementation has been seriously restricted within VA. These are the kind of things I would hope maybe we could discuss with your committee and the VA to see if there is some way, where it is profitable to VA, and proper, and would not degrade the health care, to contract out where it is beneficial to the Government.

At the present time, you know, with section 601 in that bill, we are effectively precluded from contracting out in the VA.

The CHAIRMAN. The VA already has contracting authority.

Thank you. Now, as the Chair mentioned, I will recognize anyone who would like to ask a question or make comments. Mr. Hammerschmidt?

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

Mr. Sowle, last July you testified, in answer to a question from Congressman Sawyer, that OMB was not giving consideration to the contracting out of direct patient care. I take it from your testimony and your response to the chairman's question, that that is the official position of OMB?

Mr. SOWLE. Yes, sir, that's true.

Mr. HAMMERSCHMIDT. The reason I want to make that very clear is that in answer to another question on the hearings of July 14 of this year, your written response was somewhat different. In that response you indicated that the VA should consider contracting for such things as surgical, medical, dental, and psychiatric care, hospital outpatient, nursing care, and so on and so forth. So I take it that the response you have given us this morning nullifies that response of July 14?

Mr. SOWLE. That's exactly right insofar as VA is concerned, yes, sir.

Mr. HAMMERSCHMIDT. Thank you very much. I have no further questions, Mr. Chairman.

The CHAIRMAN. Mr. Edgar.

Mr. EDGAR. Thank you, Mr. Chairman.

Mr. Chairman, I would like to follow up on the questions that you raised, particularly on the subject of food service.

Mr. Sowle, assume that you are a VA hospital director and you have gone through all of your procedures and let a contract for food services to be prepared outside the hospital and only warmed in the facility. For the first 2 weeks the food arrives piping hot and everyone is satisfied. But after that time, the food arrives cold and continues to arrive cold after repeated complaints to the contractor.

How do you then proceed to force the contractor to provide hot meals to sick patients in a medical facility?

Mr. SOWLE. First of all, Mr. Edgar, if it is important that the food be prepared at the site or nearby, and that it be hot, this would be part of the statement of work that the contractor would be obligated to perform.

Mr. EDGAR. Suppose the contractor failed on that contract for 1 day or 2 days?

Mr. SOWLE. Funds could be withheld from his contract and other similar actions taken. The contractor would be liable, or the contract could be terminated if this were a serious continuing problem.

Mr. EDGAR. How about a patient with diabetes who needs a certain kind of meal or a patient that has special dietetic needs. Is that taken into consideration at all?

Mr. SOWLE. Yes, sir. These are all taken into consideration in developing the statement of the work. This is part of the normal contracting process and part of which I tried to explain a little more fully in my statement today that I did not read.

These kinds of situations can be anticipated and taken care of in developing the statement of work and working with the contractor. I think it would be very unlikely that a contractor wouldn't be responsive if he were properly selected in the first place to meeting the requirements of the contract.

Mr. EDGAR. We have a situation at the Philadelphia hospital with the kitchen renovation. Normally this kitchen renovation could have been done by the in-house engineers, but in 1976 a contract was let for competitive bid and the businessman came in and began to work on the new kitchen.

The kitchen today is still not finished after 5 years. A substandard, old kitchen was to be replaced by this new kitchen, but unfortunately there was a problem with the work and the contract. So what was to be a 6- to 9-month process of temporary inconvenience has become a permanent problem.

When the old dishwasher breaks down in the Philadelphia hospital today because of the inability of that new kitchen to be finished, VA employees cart the dirty dishes for a whole hospital full of patients down to the canteen and wash the dishes in the snack bar facility. Arbitration over the contract and lack of performance of the contract has gone to litigation because of the delays and because of the cost overruns.

But I can tell you that the in-house VA hospital engineer who is on the job now is able to put that facility in place in a relatively short period of time. In fact, whether it is legal or illegal, the hospital director has had to order that the new kitchen be finished so that it can be used by the hospital.

I wonder if we would not have that same kind of condition if on these renovation projects all of them were contracted out and hospital engineers and maintenance staff could not do at least that part of the work that they are very capable of doing.

Mr. SOWLE. Well, I think in any case the administrator of the hospital would have authority to take care of his patients if there were some very peculiar problem, obviously, in this case that you mention, that the administrator of the hospital would be able to use his own people to go ahead and finish the job, if that's what he thought he had to do, or get another contractor.

This is not to say that contracting ever is always perfect, nor are people anywhere. You have problems with or without contractors. But in some cases where you have contractors there are remedies that can be taken by the Government to assure that its needs are met.

Mr. EDGAR. I have additional questions, but let me close with this question. I also have noticed that the A-76 proposal calls for the contracting out of VA chaplains.

I am a former chaplain at a hospital, at the University of Pennsylvania and also a former chaplain at Drexel University, ordained in the United Methodist Church. Could you explain to me how you would contract out for a clergyman's services? Would you have competitive prayers or competitive sermons—[laughter]. What standards would you use for the kind of ministers that you require. Would you have competition between Jerry Falwell and Carl McIntyre and the United Methodist Chaplaincy Service? How would you work that?

Mr. SOWLE. Sir, I am not a chaplain so I couldn't develop those standards. I would say in your case, if you're an ordained minister, and you needed a Christian minister, that should be enough. I personally wouldn't have any way of trying to come up with those criteria.

Mr. EDGAR. I suppose you would have to determine whether the clergymen are small businessmen or large businessmen.

Mr. SOWLE. We do have a lot of problems in the contracting process with that particular statutory requirement, yes, sir.

Mr. DORGAN. Would the gentleman yield?

Mr. EDGAR. I yield to the gentleman.

Mr. DORGAN. I think we would want to service them all with Lutherans. [Laughter.]

Mr. EDGAR. Well, there is a point to be made in having a couple of Lutherans on staff, but I wouldn't want to have them in all the veterans' facilities.

Well, I appreciate your answers. I have a couple of other questions that I will include with those to be answered in writing for the record.

Thank you, Mr. Chairman.

The CHAIRMAN. The Chair will recognize any other Members for questions or comments. I might say this witness' shop is the one that put out this regulation and I think it would be very good to get as much on the record as we can at this time.

Mr. Leath.

Mr. LEATH. Thank you, Mr. Chairman.

Mr. Sowle, under the terms of these contracts, whatever they might be, for custodial services, engineering, or other similar services will the contracts allow those contract employees to belong to a labor union?

Mr. SOWLE. Would the contractor? I think this would be a possibility, yes, sir.

Mr. LEATH. Would the contract that the Government would enter into prohibit those contract employees from striking?

Mr. SOWLE. No. But in each case, you know, where there is a contract awarded, if the work statement is put together the way it should be, and if the requirement warrants it—the Government can require that a strike plan be contained in the contract so that service is uninterrupted in the event of a strike.

Mr. LEATH. What do you mean by a strike plan?

Mr. SOWLE. Well, most of the contractors have other backup resources that they can bring in, and if that were a serious consideration you wouldn't necessarily contract with a small business.

Mr. LEATH. What if all the employer's employees struck? You know, patients need feeding several times a day. We can't wait a week or two for somebody to work out a situation where you can go out and pick up people off the street and bring them in to fill a service like that.

Mr. SOWLE. I don't think that would be a desirable thing to do. I think that in the strike plan the contractor would have to demonstrate how he would carry on the services in the event of a strike.

Miss Druyun may know whether or not we have had any situations of strikes in hospital care facilities——

Mr. LEATH. I'm not concerned about whether you have any. I'm just saying that if that prohibition does not exist, that that possibility is ever present. You know, I think this just points up very dramatically one of the things that is not taken into consideration in the unique nature of some of these services.

I know, as the chairman pointed out, you're not going to find a much more conservative committee in this Congress than the Armed Services Committee and almost to the man and woman on that committee, they have been very distressed and upset about the way this circular has been implemented by the previous administration. We had high hopes that when this administration came in it would take a somewhat more realistic approach to it. You know, we had instances of where they were contracting out such things as the guard service at nuclear facilities, just absolutely absurd things.

This is the thing that concerns me, and I think it concerns every member of this committee and every Member of Congress, that there are so many fuzzy areas that—"we don't know what's going to happen here; we don't know what's going to happen there." Well, it is of concern to this committee that the situation not be created where these things can be allowed to happen. Since you can't answer the question, let me ask you——

Mr. SOWLE. Well, I can answer the question on the guard service at nuclear facilities. Those are contracted today for the most part, except for one, I believe, and those have worked very well over the years. In one case there was a strike, the strike plan went into effect, and the guard service was not interrupted at all. In fact, in some cases even the agency itself would prefer to contract for those guard services because it gives them much more flexibility in bringing in people to meet unusual or unexpected requirements.

Mr. LEATH. Well, it may be working very well, but to my mind it is still not the proper way to handle such a function as that.

Could you provide for the record the names and locations of the DOD and other Federal hospitals which have awarded A–76 contracts for hospital service and give us a breakdown, please, if you would, of how many of those are for building maintenance, how many are for engineering services, and how many are for custodial services?

Mr. SOWLE. We will ask the Department of Defense for that, sir.

[OMB subsequently supplied the following information.]

All CONUS Air Force hospitals are receiving contract custodial services. The Army has 24 contracts for custodial services at the hospitals listed below. There are numerous other facilities in various DOD hospitals that receive contract services. These typically include: elevator maintenance, ADP equipment, building and structures maintenance and modification, electrical plants and systems, and medical and dental equipment maintenance. A listing of these facilities is not readily available from DOD.

ARMY FACILITIES

Fort Leavenworth, Fort Ord, Fort Fitzsimmons, Brooke Army Medical Center, Fort Lee, Fort Eustis, Fort Belvoir, Fort Hood, Fort Jackson, Fort Sill, Fort Bragg, Fort Monmouth, Fort Dix, Fort Leonard Wood, Fort Devens, Fort Meade, Fort Detrick, Fort Aberdeen Proving Grounds, Fort Polk, Fort Campbell, Fort Wainwright, Fort McClellan, Eisenhower Army Medical Center, and Letter Army Medical Center.

Mr. LEATH. In the A–76 cost-comparison process, I believe you require a 20.4 percent addon to reflect the cost of civil service retirement. Many of the VA positions targeted by A–76 have traditionally suffered high turnover of staff—and I think this is especially true in the metropolitan areas, which is probably where contracting out will have its greatest impact.

If the VA's experience is substantially different from other agencies, how can you justify requiring a 20.4-percent figure to be used without any discretion?

Mr. SOWLE. I think, if I may, I would like to ask Miss Druyun to speak to that. I believe she was a party to developing that, along with the unions and the agencies.

Ms. DRUYUN. That particular factor was developed by the Civil Service Commission's actuarians. It is a normal dynamic cost projection that was used, and there is a provision in the circular that if there is some unique circumstance in existence at a particular facility, and in the case of the VA, that they can come in and ask for a modification to that particular figure based on the data they would have developed to justify a change.

As of this time we have really never encountered a request from any of the agencies, but that does not mean we will not receive one sometime in the future. To this date, we have received nothing from the VA.

Mr. LEATH. And another, not discretionary, you require a 3.7-percent factor to offset the cost of Government-paid life and health insurance. Could you please inform the committee the basis on which OMB established this 3.7 percent as an equitable rate?

Ms. DRUYUN. OK. All of those factors, with the exception of the 4-percent contract administration factor, were figures that were derived from the Civil Service Commission's actuarial staff. Those particular figures represent actual inputs that the Government has to make.

The 4-percent contract administration factor, which is a factor that is added on to the contractor's price, was developed based on the Department of Defense's experience in administering major weapon type contracts within their Defense Logistics Agency. Based on their experience and the complexity of some of their critical systems that are developed there, it appeared—and also from some work also done in DOD with respect to administering service-type contracts, using those types of contract administration techniques employed in major weapons type contracts—that the 4 percent was a very realistic factor. Right now we are in the process of reevaluating that factor to insure it is still a realistic factor.

Mr. LEATH. Mr. Chairman, I have no further questions, but I would like to submit a statement for the record at this point.

[The statement of Mr. Leath follows:]

PREPARED STATEMENT OF HON. MARVIN LEATH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

In considering any aspect of the VA medical program, it is imperative that one keep foremost in mind that the sole purpose of this program is to provide the best medical care possible for this nation's veterans. We should strive to provide this medical care in as efficient and economical manner as possible, but we must never take any action for the purpose of economizing which would possibly lower or endanger the quality of medical care provided to veterans.

The quality of medical care provided depends upon the people providing it. It is my strong and most sincere belief that "contracting out" of the VA hospitals services as proposed by OMB Circular A-76 would, without any doubts, adversely affect the quality of patient care VA hospitals could provide our veterans. Furthermore, I am throughly convinced that rather than save money, the "contracting out" of VA Hospital services in the long run would be more costly.

When one thinks of the quality of patient care a hospital provides, we are inclined to think only of the doctors and nurses. As imporant as the doctors and nurses are, I am confident they will be the first to tell you that providing patient care is a team

effort and is affected by each service and employee of the hospital. As an example, for a large percentage of hospitalized patients one of the most important parts of his treatment is his diet. Therefore, the Food Services Department plays a most vital role in the patients' treatment program and recovery.

Furthermore, custodial service in a hospital is not just pushing a mop and a broom as might be the case in an office building. In a hospital, knowledgeable employees must perform specialized services, especially in the operating room, in order to reduce the risk of infection and other contagion.

In addition, it is truly ironic that the A-76 Circular pinpoints the engineering service for contracting out. Since 1975, the VA has conducted one of the most successful energy management programs in the federal government and it is getting better every month. The latest calculation shows that by fiscal year 1981, VA engineers had managed to reduce energy consumption in the system by 9.4 trillion BTU's saving over $39 million in fuel costs. Using both design innovations and improvements to existing structures and their systems, VA engineers estimate they can achieve savings of nearly $52.5 million in fiscal year 1982.

Therefore, a decrease in the efficiency, cooperation, and dedication of any of the hospitals' services or employees will lower the quality of care the hospital is able to provide its patients.

On several occasions, I have had the opportunity to visit and become well acquainted with the operations of the Marlin, Temple, and Waco, Texas VA Hospitals, and I am sure they are typical of the vast majority of our VA hospitals. I am greatly impressed by the caliber, the dedication, and the desire of both the management and the employees—professional and non-professional—to provide the best medical care possible for their patients, and the pride the employees have in their respective hospitals and in the services they perform. Without this individual dedication and pride in their hospital, as well as a feeling of being a part of the team, the quality of patient care would greatly suffer. It should be remembered that the hospital employees are persons who have chosen their work in the VA hospitals as their lifetime profession and for the most part have years of experience which is so valuable to any employer. Furthermore, a large percentage of the long-time VA employees are veterans themselves.

With the contracting out of the hospital services, the VA will be losing many long-time, experienced, dedicated and loyal employees. It would not be realistic to believe that the same quality of service performed by such employee would be performed by the non-VA contractor employee, who would have no real allegiance to the VA hospital management or the same level of sensitivity to the patient or the hospital's mission. The flexibility of management in the utilization of employees will be restricted if the services are performed by non-VA employees.

I do understand that President Reagan wants to reduce the federal payroll (such implementation would involve the displacement of some 22,000 VA employees of which approximately 65 percent are veterans), but I can't conceive that doing it this way would result in savings for the Federal Government. Again, I wish to point out that not only would "contracting out" be more costly, it would have an adverse impact on the services provided to veterans by decreasing the quality of patient care and ultimately affecting recovery.

A great amount of concern has been expressed to me that the cost comparison formula is totally unfair and is biased against the VA hospitals. My brief review of the formula would seem to justify that allegation. I am aware that during the course of these hearings, this subject will be thoroughly reviewed.

Even though changes should be made in the formula, it would not change the fact that the quality of patient care would be adversely affected by the proposed "contracting out" of the VA hospital services. Unfortunately, even the proposal for such unrealistic action has greatly affected the morale of the VA hospital's personnel which in itself can have an adverse impact on their work and this affects quality of patient care. Therefore, for the Administration to continue this threat of such drastic changes in the VA medical program is a disservice to those faithful and, in most cases, long-time VA employees as well as the Nation's veterans. I urge those officals in the Administration who have incorrectly conceived the provisions of Circular A-76 as a means to save money without adversely affecting the quality of care provided by VA hospitals to recognize their error, and permit our dedicated VA employees to go on with their work without the handicap of a constant fear for the future of their employment and loss of the livelihood they are able to provide their families.

The CHAIRMAN. Thank you, Mr. Leath.

Mr. Hall, also of Texas.

Mr. HALL. Mr. Sowle, I understand that in this Circular A-76 an appellate procedure is outlined. The VA circular specifically names individuals who would be responsible for reviewing and approving decisions to contract out or continue in-house. An appellate process is provided.

Now, is that set out in this circular?

Ms. DRUYUN. Yes, it is, in paragraph 11 of the basic circular.

Mr. HALL. You mention appellate procedures. To me, that indicates that if someone might be aggrieved at a contract that is issued, that the party might have the right to appeal from whatever decision might be made by the persons specifically named to arrive at a contract, whether in-house or contracted out; is that not correct?

Ms. DRUYUN. Yes. The particular procedure relates to the actual cost comparison study and any interested party who would be affected, be it a civil service employee or a contractor that submitted a bid or proposal in response to the A-76 cost comparison, is given anywhere from 5 to 15 days to review the data that went into the development of the cost comparison. If they feel any of the data in the comparison was invalid, they are able to formally appeal to the agency and ask that the decision be reversed based on the data they submit. The agency, in turn, through their appeals process, carefully examines all of the relevant data and within 30 days has to make a decision as to whether the data was correct or not.

Mr. HALL. Well, during that period of time that the appellate procedure is working, I suppose that the contract in question would be at a standstill?

Ms. DRUYUN. Yes, that is correct, sir. No award would be made until the decision was finally rendered.

Mr. HALL. Suppose that contract in question dealt with food services at a large veterans' hospital. During the time of the appellate procedure, how would the requirements of feeding those patients be handled?

Ms. DRUYUN. In the particular instance that you make reference to, the function would still be performed by in-house civil service employees and would continue to be performed by them until the particular appeal had been decided by the Government.

Mr. HALL. Well, after they exhausted the appeal and the administrative procedures, would the aggrieved person then have the right to go to court for judicial review?

Ms. DRUYUN. There have been several instances in which parties have gone into the court system and have secured a temporary restraining order, but with one or two exceptions, the majority of those have been overturned and the function has been allowed to either remain in-house or go contract based on the decision made in the A-76 cost comparison.

Mr. HALL. Well, the point I am making, though, you have two areas of review. You have the administrative appellate review which you say could take 30 days—and I am sure, with requests for extensions, you could have that extended to 60 or 90 days under the proper circumstances. And when that is completed then you can go through the judicial process of our Government, which as we all know could take a very long period of time before any conclusion might be reached. Is that not correct?

Ms. DRUYUN. The basic premise is correct, sir, but to the best of our knowledge we just recently went through a situation out at Los Alamos, at a Department of Energy facility, with the guard services. Based on that cost comparison, the employees did seek and obtain a temporary restraining order preventing the contractor from beginning a phaseover into a contract-type operation. But it took approximately 60 days for that to be finally decided and tossed out by the court.

Mr. HALL. You said something about civil service people being involved in that. Are you talking about the civil service picking up where the contract people had not started, or had completed?

Ms. DRUYUN. In the situation at Los Alamos, where the guard service had been cost-compared for possible conversion to contract and, in fact, a cost study did show about a $3 million savings over a 3-year period, the civil servants did go to court to try to seek and did temporarily obtain a restraining order preventing the Government from converting the function over to a contract operation until they had time to present their particular arguments, which rested on the fact that they believed that sort of function should not be contracted out because it is a guard service type function.

Mr. HALL. Well, do you think it is a good policy for a hospital, a veterans' hospital, to have to possibly go to court to determine whether or not certain functions will be performed in that hospital by in-house people or contracted out? Do you think that is a good policy for a hospital to have to be confronted with that all the time?

Mr. SOWLE. Well, Mr. Hall, I don't believe that would happen all the time.

Mr. HALL. If it happened any time it would be too much.

Mr. SOWLE. Well, you know, we have due process I suppose in our Government and that is a part of our Government. But the fact that this was going on, where there were administrative or legal delays, the services that had been provided in the past would continue to be provided. No action would have been taken until it was resolved, whether for a few months or longer.

Mr. HALL. When was the A-76 circular promulgated?

Mr. SOWLE. In 1955.

Mr. HALL. And has it been enforced since 1955 until now?

Mr. SOWLE. It has been enforced to different extents and different degrees since that time. It was completely rewritten in 1979.

Mr. HALL. Who is bringing force to bear here today to try to get done what you are seeking to have done?

Mr. SOWLE. I think this administration is trying to conduct business in the most economical and efficient way possible, and this is part of the system that has been in effect for some time and it looks like a very reasonable and practical way to actually bring more efficiency into the Government.

Mr. HALL. I understand from some of the information I have been furnished that since April of 1981 nothing has been done to implement action on this Circular A-76.

Who is pushing it now?

Mr. SOWLE. Well, the administration is pushing this, and I think it was April 8 when letters went out to every one of the agencies. The process is in effect. We are getting reports from the agencies

as to how far and how fast they plan to move ahead with the A–76 program.

Mr. HALL. Let me put it this way. Does this Circular A–76 have—and I have never seen it—does it have within its four corners the intention of having all services within a hospital done on the basis of a contract?

Mr. SOWLE. No, I don't—I think this is really a judgment on the part of the administrator of the hospital. It certainly doesn't intend to have all services performed by contract. It is only those services that would be more effective and more efficient to be handled by contract rather than trying to do it in-house with Government employees.

Mr. HALL. Are you saying that this would be left up to the sole discretion of the administrator of that hospital as to whether or not Circular A–76 would be implemented in his hospital?

Mr. SOWLE. I think essentially that is true. If he had some violent objection to going ahead with part of the program, he certainly would have that authority not to contract.

Mr. HALL. And if he determined that—I see some dissension——

Mr. SOWLE. I am corrected on that.

Mr. HALL. I see some dissension in the ranks there.

Mr. SOWLE. The agency head—Didn't I say the agency head?

Ms. DRUYUN. Mr. Sowle meant to say the agency head. The way the circular is written——

Mr. HALL. What did you say he meant to say?

Ms. DRUYUN. He meant to say the agency head.

Mr. SOWLE. The agency head instead of the head of the hospital.

The CHAIRMAN. That's not what he said.

Mr. SOWLE. That's true.

The CHAIRMAN. He said the administrator of the hospital.

Mr. SOWLE. Yes. I made a mistake.

The CHAIRMAN. We like that, and we would just as soon have the administrator——

Mr. HAMMERSCHMIDT. Will the gentleman yield?

Mr. HALL. Yes, I will.

Mr. HAMMERSCHMIDT. And I would ask the gentleman for an additional 1 minute.

I have Circular A–76 here, and for the record I want to quote paragraph 3: "Responsibility. Each agency head has the responsibility to insure that the provisions of the circular are followed." It goes on from there, but it's very clear here in the circular itself.

I thank the gentleman.

Mr. HALL. So if the hospital administrator decided not to have contracting out, it would have to be approved by the administrative head of the agency?

Mr. SOWLE. Depending on what the services were. Now, there are some, as I mentioned in my statement and discussed, that if they're a governmental function they are not to be contracted. Those could be service functions, but they are governmental in nature. Or, if they are direct-care type services, those are not to be contracted.

Mr. HALL. Food services, is that direct care?

Mr. SOWLE. Food service is not considered a direct care function.

Mr. HALL. I yield back the balance of my time. Thank you.

The CHAIRMAN. Any others? Mr. Dorgan?

Mr. DORGAN. Thank you, Mr. Chairman.

Mr. Sowle, you used the word "efficiency" a bit ago, and I think that is probably where I have a substantial difference with the OMB on a number of issues, and particularly in this case.

There is a substantial difference between being efficient and being effective. I think that our responsibility is to provide effective health care in these facilities for veterans and we want to do it in an efficient way, but we don't want to do it in an efficient way that loses its effectiveness. I am kind of concerned about that mentality of efficiency. My guess is that that efficiency criteria is what led some people in USDA to try and determine that ketsup was a vegetable for a while, until Mr. Stockman decided one weekend recently that it was not.

But, you know, the efficiency criteria that says "Here's the way we approach it from an efficiency standpoint." I am not sure is the way we ought to approach our responsibilities in Veterans' Administration health care.

The most vivid example, I expect, of contracted food service that we're talking about this morning is food service that you get on many airlines. I don't know whether you have been flying very much, but——

Mr. SOWLE. Not too much.

Mr. DORGAN. I think there's either a quality control problem in the airlines of America or else contracting has some real flaws when you're trying to take care of your passengers.

You know, you talk to these folks about that, and do you know what their response is? It is always "Well, we contract for that. It is somebody that we contract for that provides us food."

That raises the issue of accountability. Don't you just lose accountability when you contract for food service, contract for housekeeping and so on? Then you look at the head of a health care facility and you say "What's the problem here? Why isn't the food service up to par or why isn't the housekeeping up to par?" They say, "Well, we contract for some of that and it is hard to manage." Don't you lose accountability, in your opinion?

Mr. SOWLE. No, I don't think you do, really. In fact, I would agree with you that we're not only talking about efficiency in these contractual arrangements but also effectiveness. I have no argument with your analysis of efficiency and effectiveness. I think we use those terms also and we're talking about both things, not only the efficiency of operation but that the services are provided in a very effective way.

We do have a guide that was put out very recently to insure that statements of work for these kinds of service contracts are properly performed. This is available, of course, to all the agencies.

The contractor, as well as the contract administrators, are still accountable for the operations of the contract.

Mr. DORGAN. I recently read a GAO report in which they were talking about contracting for many, many agencies in Government. The report they gave of cost overruns and performance deficiencies is just staggering. It just occurs to me that in the area of providing health care in these facilities for our veterans, that we ought to be concerned not just about efficiency and how we can award a contract over here and obviously save some money—I assume that's

what Mr. Stockman and OMB and the administration would like to do—but how can we really accomplish the job that we're chartered to do at this point.

If you have a health care facility in which there are 100 people currently engaged in food service operations, and you go ahead and contract that out, what is to say that the company that wins that contract isn't going to provide food service with 50 people, and provide minimum requirements that perform at the bottom of that statement of work and just meet the minimum acceptable standards?

Mr. SOWLE. Well, I think you have to keep in mind that all of these contracts are actually administered by a Government employee, or Government employees. This is part of the 4-percent contract administration factor that Miss Druyun was talking about to insure that the requirements of the contract must be met. There is no way in the world that a contractor, if it requires 100 people to perform the services required of the contract—and these are not minimum services, but these are standards that are actually written out in the contract itself that will be met by the contractor—there is no way in the world that the standards could be met if it really required 100 people and he cut back to 50.

Mr. DORGAN. What is to prevent you from deciding that the people who administer the contract should be contractors? I mean, my point is, in reverse, if you trust Government employees to administer contracts, why not let them prepare the food in these health care facilities?

Mr. SOWLE. Well, in some cases I think it can be done better by contract. You have more flexibility——

Mr. DORGAN. And at less cost.

Mr. SOWLE. At less cost, yes, sir.

Mr. DORGAN. With fewer people.

Mr. SOWLE. Possibly fewer people. In fact, we found in some cases where a particular operation is being considered for a contract operation, that the Government itself comes up with improved procedures and productivity requiring fewer people to do the same job that they had been doing in the past. I believe this points to the need to try to get more effective and efficient and less costly operations. I think we are all interested in saving as much money as we can where it is cost effective and there is no loss in quality of service.

Mr. DORGAN. Well, we don't have any disagreement on that point. But I just worry that the philosophy here is "hell bent for efficiency only and save money at the expense of those who must rely on the services of our health care facilities for veterans." I guess philosophically I have some real trouble with where the administration is going on that point. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Dorgan.

Before recognizing our next member, I might remind the committee that Mrs. Smith of Nebraska is here and we will call her up in just a few minutes. Virginia, thank you for waiting.

Mr. Mica?

Mr. MICA. Thank you, Mr. Chairman. I will just take a moment. I would like unanimous consent to submit a statement for the record.[1]

Also, I would like to follow up on this point with regard to replacing individuals. I think we all too often are trying to make changes in civil service policy at the expense of everybody in Government. I just had a meeting in West Palm Beach with the maintenance crew of the Federal building. Now, it just so happens that almost every one of them are near retirement age, and every one of them has been given a notice that they are going to be replaced by contract services, and they have all been told they can go to work for the contractor at far less than they are earning now to do the same job that they're doing, and they also would lose their retirement.

I am concerned about the equity of this, not singling out government employees who are not doing a good job or those who are doing a great job, but just saying that across the board it appears to me a way to eliminate the cost of government employees is to replace them with people doing the same job at a lesser pay. In this particular instance two of the three I talked to were veterans and told, in effect, the fact that they were veterans had no bearing on whether or not they would be hired by the contractor.

Mr. SOWLE. Well, first of all, in the case where people are near retirement and their jobs are abolished, they can actually—and we found this in some cases—they can actually retire and still go to work for the contractor if they so wish. The contractor is required by the contract to hire people who are already on the job and qualified to fit into the contractor's work force. So in that case——

Mr. MICA. At the same rate of pay?

Mr. SOWLE. I think the rate of pay would have to fall within the scale that the contractor pays for his people. There is a saving factor there for the Government employee. If he does not wish to go to work for the contractor, he can take another job at the same rate of pay, if there is one available.

Mr. MICA. In the Government, if there is one available.

Mr. SOWLE. Yes, sir.

Mr. MICA. Any place in the country.

Mr. SOWLE. Yes, sir.

Mr. MICA. You see, that's the part that bothers me. I think we are facing a situation where it is not equitable, where the jobs aren't available. Obviously, the law may say you can have another job, but the jobs aren't available. And to be told—I don't care whether it is a Member of Congress or you—"you're fired, but you can come to work for me tomorrow and do exactly what you're doing today at a lot less pay"—it just doesn't sit right. And if we want to change regulations for the future, it might be a little better than to say we're going to offer this. And this is essentially what we have offered to at least the people who work for the Federal Government in my area who are affected by this. I don't think you would like it, and I certainly wouldn't like it. I think that probably the best way we can pursue this is maybe with some kind of a test program to prove over a period of time what effects this would have on the Government payroll and on the kinds of

[1] See p. 86.

problems, people problems, like the ones I have just been made aware of.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

Due to the long list of witnesses, I will include my questions to Mr. Sowle with the written questions of the chairman and ask for a timely response.[1]

Mr. SOWLE. All right, sir.

The CHAIRMAN. Mrs. Heckler?

Mrs. HECKLER. I would just ask one question. I would like to ask Mr. Sowle what assessment of savings do you anticipate as a result of pension changes? Has the OMB evaluated and assessed pension reductions, Government responsibilities on pensions as a result of this transfer of function?

Mr. SOWLE. I don't believe we have any data on that.

Mrs. HECKLER. In other words, my question is related to the question of the transfer of function by the employee who then on the outside has the right to become a private contractor or work for a contracting firm. If large numbers of employees do this, the Government pension liability to the employee is reduced; isn't that the case?

Mr. SOWLE. Well, in the event that their job is abolished, as I understand—and I'm not a personnel expert—but in the event the job is abolished, and they have the appropriate number of years of service and age then they can retire and pick up their pension at that point. Mrs. Druyun has some other data on this subject.

Ms. DRUYUN. If an affected employee, let's say, had 10 years of service and the particular function they used to perform was found to be more cost effective by doing it through a contract operation, the employee is free to leave his or her retirement funds in the civil service retirement fund and elect—whatever the age requirement is now, age 62 or 65, I'm not certain—at some future time in their life to have a small pension from the Government.

I would like to say that those types of factors were taken into consideration when the retirement cost factor was developed through the Civil Service Commission, which is now the Office of Personnel Management.

Mrs. HECKLER. Therefore, the decisionmaking was based on a short-run analysis of cost savings, immediate cost savings, and a long-term analysis of the long-term liability of the Government to employees through a pension responsibility?

Is that correct?

Ms. DRUYUN. In essence, yes. I am not an actuarian, so I really cannot talk to that type of analysis.

The CHAIRMAN. Thank you. Mr. Edgar.

Mr. EDGAR. Thank you, Mr. Chairman. I just have two quick questions.

The committee has learned that 67 percent of the potentially displaced employees in the Department of Medicine and Surgery were employed under one of the veterans' preference authorities

[1] See p. 287.

provided by the Federal Government and by Congress. The charge has been made that with A-76, OMB is usurping veterans' preference in the Federal employment system.

How do you answer that charge? How do we, as the Veterans' Affairs Committee, and as Members of Congress, justify moving away from those veterans' preference requirements?

Mr. SOWLE. Go ahead.

Ms. DRUYUN. There are a number of contractual requirements that are placed on contractors, and some of those are, for instance, EEO requirements that the contractor has to meet, and the hiring of veterans, such as in the veterans' preference clause. We would be happy to submit for the record the content of those contractual requirements.

Mr. EDGAR. If the gentlewoman would yield, does the contractor have to abide by the 10-percent preference for disabled?

Ms. DRUYUN. The contractor has to abide by the particular Executive order and the legislation that put those particular requirements into a contract.

Mr. EDGAR. But I am asking the specific question, that there are certain preferences, a 5-point and 10-point preference for Federal civil service that are not requirements of the private sector.

Would special consideration for veterans' employment be mandated for every one of the contracts and contracting out under the experience of the Department of Defense and other departments that already use this A-76 Circular?

Ms. DRUYUN. I cannot specifically answer your question, sir, but we will supply it for the record.

[OMB subsequently submitted the following information:]

FPR Temporary Regulation 39 has its basis in the Vietnam Era Veterans' Readjustment Assistance Act of 1972. In general, it requires contractors with contracts in excess of $10,000 to take affirmative action in employing veterans, precludes discrimination, and requires listing of openings with local employment offices. In this respect the requirements are roughly similar to those placed on the Federal Government as an employer. However, the FPR does not mandate any specific features of a contractor's affirmative action program. We were unable to discover any data that would allow us to directly compare the results of private sector programs to those of the Federal Government.

While the FPR does not mandate any specific contractor hiring practices, OMB Circular A-76 does. Paragraph 10 of the Circular requires agencies to include a provision in the contract that gives Federal employees displaced as a result of conversion to contract performance the right of first refusal for employment openings on the contract in positions for which they are qualified.

We believe that the veterans preference clause in Federal contracts, when taken in conjunction with other contract clauses relating to equal employment opportunity and hiring the handicapped, and the unique Circular A-76 clause giving displaced employees the right of first refusal offer a very favorable employment opportunity for veterans. The net effect of the right of first refusal clause for procurements related to Circular A-76 cost studies is to give absolute hiring preference to qualified displaced Federal employees that are veterans. Thus, we do not believe any further action is necessary to enhance their employment opportunity under contracts.

Mr. EDGAR. I think there is a real question for all of us about the whole question of veterans preference. The 67 percent of these persons displaced have been hired under that requirement. Allegedly many of them will not be part of this new system.

Let me just ask one final question. It occurs to me that if you have 100 persons working in food service, and you replace them with 90 or 100 persons in the private sector, you make a public

announcement as a new administration of what contribution you have made to the society by getting Government off people's back and out of their pocketbooks, and you have reduced the number of Federal employees.

Have you, in fact, reduced the kinds of jobs and responsibilities that the Federal Government has to provide basic service in the veterans' system? What contribution have you made to society by shifting those 100 workers from one system to the other?

We had an incident with the agent orange study. Because of the Federal hiring freeze, the Center for Disease Control in Atlanta had to contract out the agent orange birth defects study at a 50-percent increase in cost. I am just not confident that we're not just moving bodies from the Federal employment service to the private sector, announcing the fanfare that Government is off of people's backs and out of their pocketbook, but in fact Government is still providing those basic services of engineering, of custodial care and of health care for the same veterans that are coming to the veterans hospitals.

Mr. SOWLE. I think the response to that, Mr. Edgar, is that when you make the analysis of the cost of a contract operation versus doing it in-house, you are also making an analysis of how effective and how efficient the total job is being done. To that extent, whether these people are working within the Government or outside, I think the Government actually comes out ahead in terms of not only the employment but also the effectiveness and efficiency with which the job is performed.

Mr. EDGAR. So you're getting lots of complaints that the food service is bad in the veterans' hospital; the janitorial service is bad; the engineering is all bad, and that's why it has to be contracted out to the private sector?

Mr. SOWLE. I'm not sure about what complaints the VA has received, if any, in this area.

Mr. EDGAR. Thank you.

The CHAIRMAN. Let me say to the members that whether you ask a question or not, it has been the Chair's practice, since I became chairman, that the record will show every member who attended the hearing whether they ask a question or not. I think that is only fair to those members who do come and maybe at that time do not want to ask any questions.

It seems to me, Mr. Sowle—I think I'm correct in this—that the Veterans' Administration has the authority now for general contracting out, and what you, in effect, are doing at OMB is giving some specific guidelines—in other words, ordering the Veterans' Administration to contract out; is that correct, where they might not want to do it?

Mr. SOWLE. I don't think that is exactly the right way to state the situation. The Veterans' Administration now, under the law that the President signed Saturday, may not spend money for cost comparisons. Under the OMB's instructions today, cost comparisons should be made for all commercial/industrial-type activities except those precluded by statute.

Now, I would think the Veterans' Administration would like to have some flexibility to contract out where they know it is to the advantage of the administration to do so. To that extent, I think we

would like to work with this committee and the VA to determine specific areas where contracting out would be beneficial to the VA.

The CHAIRMAN. Mr. Sowle, under section 213, title 38, the VA has that authority now. Basically, I'm on your side. Anyway that we can save funds in the Government—and this committee took action to cut back on some veterans' programs—we should do it if practical and feasible. But I think it is the general feeling in this committee that when you start talking about contracting out of medical care and dietetic food service, you're really getting into some problems. The DOD has tried this, as I understand it, and no Defense hospitals are now contracting out their food services as far as we can find out.

Ms. DRUYUN. Sir, we will submit for the record the names of approximately a dozen hospitals, for instance, within the Air Force where their food service operation, in essence, has been contracted out. We will also submit for the record the names of all the facilities, particularly those in the Air Force, where their custodial service has been contracted out, including their critical care areas.

They are also in the process right now, the Air Force as well as the Navy and the Army, of conducting cost comparison studies for their plant operations and maintenance functions in a number of their larger hospitals. Those we will also submit for the record.

[OMB subsequently supplied the following information:]

As we stated in our testimony, the food service function for twelve Air Force base hospitals is not being accomplished by personnel integral to the hospital operation. At these installations the food is prepared by the base dining hall and transported to the hospital. The operation of the dining hall is a combination of Air Force cooks and contractor food service attendants. There is no separate contract price associated with preparing food for the hospitals. Whatever special diets are required are prepared by the base dining hall. There is no feeding in the hospitals for personnel other than patients. Our reason for citing these hospitals as an example is that we believe preparation of patient food can be accomplished without the source of preparation being under the direct control of hospital management. In addition, the Navy has food service contracts in the following hospitals: Naval Aerospace and Regional Medical Center, Pensacola, Florida; National Naval Medical Center,[1] Bethesda, Maryland; and Naval Regional Medical Center, Camp [1] Lejeune.

The Air Force hospitals where this mode of operation is in effect are: Blytheville AFB, Arkansas; Castle AFB, California; F. E. Warren AFB, Wyoming; Grand Forks AFB, North Dakota; Griffiss AFB, New York; K. I. Sawyer AFB, Michigan; Loring AFB, Maine; Molstrom AFB, Montana; McConnell AFB, Kansas; Plattsburg AFB, New York; Whiteman AFB, Missouri; and Wurtsmith AFB, Michigan.

In addition, the Navy is presently conducting cost comparison studies on their hospital food service operations at the following locations: Naval Hospital, LeMoore, California; Naval Air Station, Miramar, California; Naval Regional Medical Center, Camp Pendelton, California; Naval Regional Medical Center, Long Beach, California; Naval Regional Medical Center, Oakland, California; Naval Regional Center, San Diego, California; Naval Sub Regional Medical Center, Subase, New London, Connecticut; Naval Aerospace and Regional Medical Center, Pensacola, Florida; Naval Regional Medical Center, Orlando, Florida; Naval Regional Medical Center, Jacksonville, Florida; Naval Regional Medical Center, Great Lakes, Illinois; Naval Medical Center, Bethesda, Maryland; Naval Hospital, Patuxtent River, Maryland; Naval Regional Medical Center, Camp Lejeune, North Carolina; Naval Regional Medical Center, Philadelphia, Pennsylvania; Naval Regional Medical Center, Newport, Rhode Island; Naval Hospital, Beauford, South Carolina; Naval Regional Medical Center, Charleston, South Carolina; Naval Regional Medical Center, Memphis, Tennessee; Naval Regional Medical Center, Corpus Christi, Texas; Naval Regional Medical Center, Portsmouth, Virginia; and Naval Regional Medical Center, Bremerton, Washington.

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[1] Part of the food service function is under contract and the remainder is undergoing a cost study in FY 1982.

A list of DOD facilities under A-76 comparisons for plant operations and maintenance follows:

Air Force: Mather, Shepherd, Fairchild, Minot, and Grand Forks.

Army: Walter Reed and Fitzsimmons.

Navy: Navy Regional Dental Clinics: Pendelton, Long Beach, San Diego, Jacksonville, Florida, Orlando, Florida, Pensacola, Florida, Pearl Harbor, Great Lakes, Bethesda, Camp Lejeune, Roosevelt Roads, Newport, Charleston, Parris Island, and Norfolk.

Naval Hospitals: Lemmore, California, Paxton River, Cherry Point, Beauford, South Carolina (and Dental), and Woodby Island.

Regional Medical Center Public Works: Bremerton, Pendelton, San Diego, Long Beach, Port Hueneme, Jacksonville, Orlando, Great Lakes, Camp Lejeune, Philadelphia, Quantico Clinic, Newport, Charleston, Memphis, Corpus Christi, Portsmouth, and National Naval Medical Center.

[Attachment]

DEFENSE AUDIT SERVICE,
Arlington, Va. 22209, May 27, 1980.

Memorandum for Deputy Assistant Secretary of Defense (Supply, Maintenance and Transportation).

Subject: Review of commercial or industrial type activities converted to contract in fiscal year 1977 (project OSI-032).

We have completed our review of Commercial or Industrial Type Activities (CITA) converted to contract in fiscal year 1977. The objectives of the review were to determine the extent of cost growth on in-house CITA operations converted to contract in fiscal year 1977 and to determine the reasons for abnormal cost increases.

We identified 39 CITA functions at 30 military installations that were converted to contract in fiscal year 1977. Since that time, cost growths for 20 of the functions at 18 installations exceeded the annual inflation rate for at least 1 year.

We examined 10 of the 20 CITA functions with cost growths greater than the annual inflation rate. For 8 of the 10, we found that the increases were primarily attributable to significant additions to the scope of work required. For example, the total cost of custodial contracts at the Naval Public Works Center, Great Lakes, Illinois, increased by 335 percent between fiscal year 1977 and fiscal year 1980. Annual cost increases ranged from 23 to 180 percent. We found that the cost increases were due primarily to increased work requirements. The actual square footage covered by the custodial contracts increased by 384 percent between fiscal year 1977 and fiscal year 1980. Consequently, the actual cost per unit of work did not increase.

The 2 cases where cost increases were not related to increased work requirements involved food service operations at Holloman Air Force Base and at Fort Benjamin Harrison.

At Holloman Air Force Base, the contract price increased about 145 percent and the cost per meal served (a guide for evaluating food service attendant contracts) increased 51 percent between fiscal year 1977 and fiscal year 1978. The apparent reason for the sharp increase was an erroneous "under bid" by the contractor. Within a few weeks after the contractor commenced performance, he claimed he was "misled" by the manning chart contained in the Air Force solicitation and as a result significantly underestimated his bid.

The bid solicitation included a manning chart that showed the suggested number of mess attendants needed by half-hour increments to accomplish the work. This chart was furnished as a guide only. Holloman AFB, the Tactical Air Command and the Air Force Logistics Command disagreed with the contractor's claim and disallowed it. The Air Force Contract Adjustment Board, however, overruled this decision and ultimately directed Holloman AFB to pay the contractor an additional $85,296. This amount, when added to the original contract price, may have exceeded the cost to keep the function in-house. Since this was a specific set-aside contract, it no longer falls under the CITA program requirements for periodic follow-up review. Consequently, the contractor with satisfactory performance is almost guaranteed the future work even though his costs may exceed the costs to perform the function in-house.

The food service contract cost at Fort Benjamin Harrison increased 25 percent between fiscal year 1978 and fiscal year 1979. The reason cited for the price increase was the inclusion of minimum staffing requirements in the succeeding fiscal year 1979 contract. The contracting officer included the minimum staffing requirement because the contractor had frequently submitted invoices and was paid for work that he claimed was over and above the original contract requirements. In our

opinion, the contractor's claims that the work he performed was over and above the original contract requirements were questionable. For example, the bid solicitation required complete sweeping, cleaning and mopping. The solicitation also noted that the dishwashing equipment had a history of rather frequent mechanical breakdowns. The contractor should have considered the implications of these conditions in his bid. However, when the dishwasher broke, he invoiced for additional labor to move the dishes to the alternate dishwasher and for labor to clean up the water from the inoperative dishwasher. The contractor was obligated to report inoperative equipment to the post engineers; however, we were unable to identify any work orders where the contractor requested the equipment be fixed.

Based on our review, it does not appear that contractors of CITA functions are bidding low and then unrealistically raising their prices on subsequent contracts.

EDWARD R. JONES,
Acting Associate Director, Systems and Logistics Audits.

The CHAIRMAN. Is this managing some of these——

Ms. DRUYUN. No, sir. It is full operation of the particular function by a contractor.

The CHAIRMAN. We had the Navy testify before us on one of their naval hospitals which contracted out. They testified it was a disaster and that the contracting firm left them and they had to come up with some way to feed the patients. We'll have to look into the Air Force——

Mr. SOWLE. Could I ask, sir, if that is a recent contract, or one that goes back several years?

The CHAIRMAN. Yes. It was a couple of years ago; however, that doesn't make any difference if it didn't work.

Mr. SOWLE. Except that the statements of work now have been developed to a much better level, a higher degree, and I think have prospects of much greater success in contracting out than many contract experiences going back several years.

The CHAIRMAN. Why do you say that?

Mr. SOWLE. Because the technique of developing statements of work had not been developed to the point where they were as effective as we think they are today.

The CHAIRMAN. We'll end on that. Thank you very much.

Our next witness will be Mrs. Virginia Smith, a Member of Congress from Nebraska. We appreciate her patience and we would like to hear from Mrs. Smith.

STATEMENT OF HON. VIRGINIA SMITH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEBRASKA

Mrs. SMITH. Mr. Chairman and members of the committee, I appreciate this opportunity to express my concerns to the application of OMB's Circular A-76 to the VA health care system.

There are three VA hospitals in Nebraska that are subject to the circular—in Omaha, Lincoln, and Grand Island in my congressional district. The center in Grand Island serves 58 counties, including 13 in Kansas. It is a 204-bed facility, with a 67-percent annual average occupancy rate.

It has 286 full-time and 42 part-time employees, and served 2,778 inpatients and 18,800 outpatients during the last fiscal year. Its pharmaceutical, plant maintenance, food preparation, administrative, supply, custodial, media, keypunch, chaplain, and laundry services are scheduled for studies to determine whether outside contractors can carry out such services more cheaply than in-house employees.

I placed the chaplain service next to the last because this is where it appears in OMB's Federal Register notice, but I hasten to join Congressman Edgar in saying that it puzzles me. I don't know of any commercial vendors of spiritual services, although maybe OMB knows of some sort of "Dial-a-Prayer" service that I'm not aware of.

Scores of patients and employees and other citizens in the Grand Island area have written to me protesting the application of this circular to our veterans' hospitals. In their interest and in the interest of all the veterans in Nebraska, I hope you will consider it very carefully.

I object to the circular for two main reasons. First, the application of this circular to the VA hospitals is based solely on the goal of saving money.

Now, as you know, I am a Member known for frugality, particularly, but not exclusively, with the taxpayers' money. But I believe that when the health—the very lives—of people who have served our country are at stake, it is inappropriate to consider only cost. I think the quality of health care services should have prime consideration.

Moreover, it is my understanding that the studies alone will cost nearly $30 million, and I am thinking of how many renal dialysis procedures or chemotherapy administrations could be made for the cost of these studies.

I do want to compliment you, Mr. Chairman, for your efforts to get language in S. 917 to prevent veterans' health care funds from being used to conduct these studies.

Second—and I think you touched on this, Mr. Chairman—it seems to me that this violates title 38 by taking authority from the Department of Medicine and Surgery for determining the rules, the procedures, and the limitations on the delivery of services in the VA health care system. It seems to me that this is a usurpation of authority by an agency of Government that has no knowledge of or experience with the health needs of veterans and that it really goes against Congressional intent.

So I should like, in conclusion, to say that extension of this circular to the VA is a challenge to the health network that has been carefully and deliberately nurtured for many years by this committee and its counterpart in the Senate to provide quality care for the Nation's veterans.

I congratulate you for your interest in having this hearing and for your concerns, and as a Representative of the Third District of Nebraska and a member of the Appropriations Committee, I certainly want to work with you to provide adequate protection for the quality of health care of our veterans.

[The prepared statement of Hon. Virginia Smith appears on p. 86.]

The CHAIRMAN. Thank you, Mrs. Smith, for your very fine testimony. We have seen your abilities on the Appropriations Committee and also on the floor, and your effectiveness.

Let me mention one item. The President has just signed the "Veterans' Disability Compensation, Housing and Memorial Benefits Amendments of 1981" which says that no funds could be taken out of the medical care accounts of the Veterans' Adminis-

88-005 O—82——3

tration to make these studies. We didn't think it was fair to take this estimated $10 to $30 million to make the studies, to take it away from patient care.

My question to you is, where does the VA or where does OMB get the money? You're on the Appropriations Committee. What happens now?

Mrs. SMITH. This was a part of my concern, that this $30 million, as I understand it, would come out of the funds that had been appropriated for veteran medical care.

The CHAIRMAN. In the bill that the President has just signed we said none of this funding can come out of these medical accounts.

Mrs. SMITH. And we have not taken any action on this, in terms of the appropriation.

The CHAIRMAN. You haven't taken any action in the Appropriations Committee.

Mrs. SMITH. No.

The CHAIRMAN. That was my question.

Well, I certainly hope you take a good look at it. If OMB asks for $30 million——

Mrs. SMITH. I will see that we take a very good look at it.

The CHAIRMAN. Does anyone have any questions of Mrs. Smith? Mrs. Heckler?

Mrs. HECKLER. I would just like to congratulate Mrs. Smith on a very fine statement. I think it is particularly appropriate that you spoke out today because we all know how cost conscious you are on the Appropriations Committee. I think you can be a valuable watchdog for this committee in that other role, where obviously the funding will have to somehow be channeled through the appropriations process in order to continue to pursue the studies under suggestion. I would hope the gentlewoman will carry her strong concerns for veterans which I know have always existed to all the deliberations of the Appropriations Committee where we are going to have many other struggles for funding of veterans' hospitals and veterans' medical care.

Mrs. SMITH. Thank you.

Mr. EDGAR. Mr. Chairman, just one quick question.

I appreciate your statement and join you on the issue related to the clergy. It seems to me there is a little bit of contradiction at the White House and at the Office of Management and Budget. I wonder if you know whether or not the secretarial pool at the White House is contracted out.

Mrs. SMITH. I do not know.

Mr. EDGAR. I wonder if there are services that OMB provides which couldn't be done more efficiently by people from the outside.

Mrs. SMITH. That's something to think about, but not at the price of the integrity of the VA.

Mr. EDGAR. Thank you.

Mrs. SMITH. Thank you, Mr. Chairman.

The CHAIRMAN. One other thing, Mrs. Smith. You touched on quality care, which I think is very important in these critical times. Considering the number of Vietnam era, Korean and World War II veterans potentially eligible for health care. I think we have got to be very careful how we handle these situations and gear toward more quality care in these areas of medical treatment,

food service and nursing home care because of the problems we are going to face. So I appreciate your emphasis on quality care. It is certainly important at this time, in my opinion.

Next we ask Mr. Clyde Cook, with his panel to come forward and introduce these panel members. Some of them are very familiar to this committee and have testified before.

STATEMENT OF CLYDE COOK, ASSISTANT DEPUTY ADMINISTRATOR FOR PROCUREMENT AND SUPPLY, VETERANS' ADMINISTRATION, ACCOMPANIED BY DR. DONALD L. CUSTIS, CHIEF MEDICAL DIRECTOR; MARJORIE QUANDT, ASSISTANT CHIEF MEDICAL DIRECTOR FOR ADMINISTRATION; AND ROBERT COY, DEPUTY GENERAL COUNSEL

Mr. COOK. Thank you, Mr. Chairman.

On my far right is Marjorie Quandt, who is the Assistant Chief Medical Director for Administration; of course, Dr. Donald Custis, Chief Medical Director who is known to you all. Mr. Robert Coy is, the Deputy General Counsel of the Veterans' Administration.

The CHAIRMAN. You may proceed. If you could summarize, it would certainly help us and talk right into the microphone, Mr. Cook.

Mr. COOK. Yes, sir.

Mr. Chairman, the signing of the recent legislation makes some of the testimony that I will provide somewhat moot. Nonetheless, I would like to describe to you where we were in our actions on Circular A-76 up until at least Saturday of this past week.

In our July 14 testimony before the Oversight and Investigations Subcommittee, we pointed out the magnitude of the problem facing the VA in complying with A-76. It involved several thousand employees and over $620 million in operating costs annually, and over $400 million in capital outlay.

Since that testimony, the Veterans' Administration has issued its own internal instructions on how we were to proceed under A-76. This was the publication which is labeled VA Circular 00-81-32, dated July 30.

It established the internal management structure for undertaking A-76 reviews. And it provided specific guidelines with regard to the process itself. In addition, in August and October of this year we published in the Federal Register a schedule of the dates on which we proposed to begin cost studies of the so-called commercial industrial activities.

In response to a question of the committee, in notifying us of the hearing, we have received no instructions from OMB since April of 1981 regarding our implementation of A-76. However, they are aware of our internal directive.

Our directive noted that the magnitude of the review program required that it be decentralized. Accordingly, the heads of field activities are directed to organize management teams to conduct the reviews of the functions to be studied.

I am certain it is the creation of these management teams that has aroused the interest of many throughout the country. We asked that each team be headed by a senior management member of the facility staff, and include representatives of other special areas whose expertise was involved.

For example, those in personnel, supply, and engineering in the medical centers. The reviews are to be accomplished after developing work statements for each individual commercial—industrial activity to be reviewed. Under our procedure, notice would be placed in the Commerce Business Daily to prospective interested firms to advise them that we were considering these reviews.

If we receive two or more responsible firms indicating willingness to compete for a contract, we then would proceed with a cost study and solicitation of a contract.

If we received, as a result of this cost study and this solicitation bids from two or more responsible, responsive bidders, we would then compare the Government cost study with the bids to determine which offered the lowest overall cost.

Our VA circular also specifically named individuals who were responsible for reviewing and approving any decision to contract out or to continue in-house. And it established an appellate process.

The cost comparison process in Circular A-76 is quite detailed. And for this reason, we have conducted two major training seminars for over a total of 550 personnel from our field activities who would be potentially involved in these studies.

We had plans for other training sessions which would focus on the various disciplines directly involved in the cost analyses. Mr. Chairman, since the preparation of my written statement to you, the President did sign the Veterans' Disability Compensation, Housing and Memorial Benefits Act of 1981.

The enactment of section 601 of this legislation, in effect, stops the VA from further action in our medical care program at this time, and we, at this point, I must say, we are stopped, and there will not be further action, at least of which I am aware, or which is contemplated at this time.

This section of the statute proscribes the use of funds appropriated for medical care, medical prosthetic research, and medical administration and miscellaneous operating expenses for use in conducting Circular A-76 studies in the Department of Medicine and Surgery.

There are some commercial—industrial activities outside the Department of Medicine and Surgery. Some 523 of them affecting 1,806 employees. These are basically located in the Department of Veterans' Benefits, Department of Memorial Affairs and the staff of the central office.

The VA, Mr. Chairman, under the authority of A-76 has exempted some of its activities in this inventory for further review. I might say our interpretation of the conditions under which the Administrator is authorized to make exemptions in the circular itself are somewhat specific and rather limited. It is not a broad, general authority that can be exercised without meeting a number of conditions.

The exemptions we have granted to date have not, incidentally, been on the basis of the threat of strike or work action. That probably is because of the nature of the contracting out that has been looked at to date.

Mr. Chairman, I would like to emphasize that the Veterans' Administration does rely, in many instances, on the private sector to provide services that are needed. In a procurement budget of a

little bit over $2 billion, approximately $700 million is for services that are classified as commercial—industrial, for which we contract out.

For example, in fiscal year 1981, we contracted for approximately $73 million for travel, including ambulance and hired car service, which is a major item.

Approximately $9 million was for automated data processing services, $72 million for maintenance repair services, including upkeep of roads, walks, and grounds; $15 million for veterans' counseling; $23 million for the repair of equipment.

To illustrate where we think through prudent judgment we have a good mix of in-house and contract services, we could look at our plant maintenance function. Of the $622 million expended nationwide in the fiscal year 1980, for the maintenance and repair and operation of 172 health facilities, nearly half, $292 million, was expended through contracts.

Again, of the $42 million in the cost for the biomedical engineering repair maintenance and inspection, over $20 million was for contractual services. Virtually all of the $130 million expended for nonrecurring maintenance is through contract. We think that this illustrates that the VA does rely upon the private sector where it is both effective and efficient and economical.

We expect there will be occasions in the future where it will be necessary for us to contract for services, not necessarily because of the requirements of A-76, but because of many factors. And that is where we deem it beneficial from both a management and an economic standpoint.

Mr. Chairman, this concludes my remarks. We would be happy to answer any questions.

[The prepared statement of Mr. Cook appears on p. 87.]

The CHAIRMAN. Thank you, Mr. Cook. Your right-to-the-point testimony certainly helped me. Some people might have the impression you weren't doing any contracting out. But you are contracting out. Is that correct?

Mr. COOK. Yes, sir.

The CHAIRMAN. Under existing provisions in title 38.

Mr. COOK. Yes, sir.

The CHAIRMAN. And you are doing over $800 million a year of contracting out.

Mr. COOK. $700 million.

The CHAIRMAN. How much?

Mr. COOK. $700 million.

The CHAIRMAN. $700 million.

Dr. Custis, in your personal opinion, do you think that you need more guidelines and more specific instructions from the Government on contracting out or are you comfortable with the way the law is now?

Dr. CUSTIS. I am very comfortable with the way the law is now, Mr. Chairman. We do, indeed, need contracting authority as a management tool. But we use it where it is clearly in our interest to do so, especially in terms of being unable to make other provisions. Specifically, for example, in the area of clinical care, where, in certain areas, due to the high salary scales of certain specialists,

we must resort to contract for a physician's services; a radiologist, for example.

I think, without exception, that when we go this route, we do it with considerable reservation, not only is it very expensive, but also it is a fragmentation of what more properly should be an integrated in-house patient-care team.

As for nonclinical types of contracting there is little I can add to Mr. Cook's testimony, except to say that we have the capability of satisfying our needs.

The CHAIRMAN. Actually, I am familiar with this, having visited different veterans' hospitals. I know that some of the special care such as radiology is very expensive when you have to contract it out. As far as medical care is concerned, the contracting out is awfully expensive. Is that correct? You would be much better off if you had radiologists on board working for the Veterans' Administration?

Dr. CUSTIS. I am sure you would be interested in knowing that we are much more successful in recruiting our own staff physicians, thanks to Public Law 96-330 and the increased physician bonus, than we had been. But even with that increased bonus, we can't match salary scales of over $150,000 a year for radiologists in certain areas of the country.

I might also register a concern that is not unrelated to your question, Mr. Chairman. I am gratified to know that OMB accepts our General Counsel's interpretation of A-76. This is the first time I have heard this.[1]

However, I still have some anxiety over the definition of "direct patient care." And it stems from those times when a personnel freeze was in effect. Exemption was given for direct patient care personnel. That was interpreted by OMB as referring only to the physician and the nurse.

The health care team directly serving a patient involves far more than the physician and the nurse. It is essential that it be an integrated team effort, with such personnel as the X-ray technician, the laboratory technician, the psychologist, the pharmacologist, physiotherapist, and yes, indeed, the dietitian and certainly the chaplain, and the social worker.

I think it remains to be seen whether we are using the same dictionary in our current interpretation of direct care personnel.

The CHAIRMAN. Thank you, Dr. Custis.

Do any members have questions for our witnesses?

Mrs. HECKLER. I would just like to ask Dr. Custis what percentage of the overall funding of VA medical services actually is contracted out today.

Dr. CUSTIS. I am sorry, Mrs. Heckler, I couldn't hear you.

Mrs. HECKLER. I am saying what percentage of the overall medical care costs are presently contracted out today?

Dr. CUSTIS. Are you talking about the clinical-type contract?

Mrs. HECKLER. The whole medical field.

Dr. CUSTIS. That is the $700 million figure.

Mr. COOK. The figure is larger than $700 million. That does not include all fee basis.

Dr. CUSTIS. Oh, the fee basis.

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[1] See opinion of VA general counsel on p. 89.

Mr. COOK. Probably about $900 million.

Mrs. HECKLER. $900 million out of a budget of what?

Dr. CUSTIS. The medical care budget has been averaging about $6.5 billion.

Mrs. HECKLER. $6.5 billion. So, $900 million is presently contracted out.

Mr. COOK. We would like to verify that figure and provide it for the record. We do not have it with us.

[Subsequently the VA supplied the following information:]

The total for 1981 was $712 million.

Mrs. HECKLER. Other than the radiologists, what other categories or functions would fall within contracting out services?

Dr. CUSTIS. Notably—in certain geographic areas—radiology, pathology, and anesthesiology are the common high-cost categories.

Mrs. HECKLER. In the past, the Veterans' Administration has largely contracted out in those areas in which the fees or compensation associated with the function are so in excess of the budget of the VA hospital—VA medical system, that there would be no way to accommodate those fees within the system, and that was the reason for the contracting out; is that correct?

Dr. CUSTIS. That is right.

Mrs. HECKLER. This proposal to contract out a vast number of other more ordinary services flies in the face of all of the experience of the VA. It has never been before; is that correct?

Mr. COOK. It has been done before, but we have done it where we had a number of compelling reasons and not just the bottom line cost figure.

Mrs. HECKLER. What is the projected, if all of these services were contracted out according to the proposal for assessment, percentage of decrease in the VA employee level?

Mr. COOK. What I will describe is the worst case; that is, the absolute maximum it could be would be around 36,000 employees; 36,000 employees.

Mrs. HECKLER. 36,000 employees out of how many employees presently?

Mr. COOK. About 120,000—No, 184,000.

Mrs. HECKLER. From 36,000 maximum out of 184,000. And what function then would be exclusively within the purview of the VA employees.

Mr. COOK. Within the VA?

Mrs. HECKLER. Yes.

Mr. COOK. Of course, the direct medical care function, which certainly we interpret as including the many things Dr. Custis mentioned in addition to the physician; there are the technicians and sociologists and others.

Mrs. HECKLER. Nursing staff.

Mr. COOK. Yes.

Mrs. HECKLER. I can't imagine that there would be private contractors for nursing staff, but you never know.

Mr. COOK. There are, but they are outrageously expensive.

Mrs. HECKLER. Very expensive. Thank you.

The CHAIRMAN. Mr. Edgar?

Mr. EDGAR. Thank you, Mr. Chairman. I appreciate the panel coming and sharing their views. Dr. Custis and Mr. Coy, I under-

stand that you had to appear before another committee of Congress yesterday under less pleasant circumstances than you are appearing today. From what I heard of the proceedings of that committee of Congress, I want to commend you and your staff for a job well done.

I think you operated yesterday under pretty difficult circumstances. I also want to assure you that I continue to have a great deal of respect and continue to support the kind of job that you are trying to do.

I also think that Dr. Crawford and Dr. Ewalt should be commended for the work they are trying to do with the Readjustment Counseling Centers and other issues of importance to Vietnam era veterans. Sometimes the work of some of the people within the bureaucratic side of the Federal Government does not get complimented. I think you are to be commended for your ability to stand up under a little tough questioning and some pressure yesterday, and I think we haven't heard the end of that particular discussion. I think there are some other points that have to be made.

Dr. Custis, I wonder if we could go back to your listing of the medical services and what fits in terms of direct and indirect service.

We were talking earlier with OMB and raised some questions and illustrations about delivery of food service. I wonder if you could take a moment to talk about food service in relationship to health care within a hospital system? Is food service part of the treatment of a patient and in what ways does that food service become part of the integral delivery of direct health care within a hospital?

Dr. CUSTIS. Mr. Edgar, I thank you for your kind words, first of all. I find difficulty in lumping all food service into one category. There is a very important element in food service; namely dietetics, where a physician's prescription for diet must be well understood and followed by a professional dietician, and she must have supervisory control over the preparation of those diets.

I would divorce that service from the run-of-the-mill food delivery that is given to other patients and staff in a hospital that are not in need of special diets.

Mr. EDGAR. Dr. Custis, if I could interrupt you at that point, and I respect that differentiation, which is very important. Could you conceive of a contract which would contract out those meals for staff and not-too-sick patients versus those meals that had to be prepared under the close supervision of a dietician?

Dr. CUSTIS. It has been done, Mr. Edgar. It is being done by some hospitals.

Mr. EDGAR. So, it actually would be a division of the contract.

Dr. CUSTIS. Yes, sir.

Mr. EDGAR. Do you know if that is working very well?

Dr. CUSTIS. I am pretty sure we have an example right here in town of the Washington Hospital Center, don't we?

Ms. QUANDT. We have had trouble with special diets; therefore, they changed the contract so that the special diet preparation is done in-house with the hospital staff. This is an added expense.

Mr. EDGAR. I think that is an area that we really have to study carefully if there is any proceeding with the A–76 circular be-

cause I am familiar with hospitals and how they work and see very often the relationship between the patient and the meal that arrives and not only the quality of that meal, but the kind of containers and conditions it arrives in and whether or not it can be easily consumed by the patient. I think it is a question we need to raise.

One other question that I have relates to regional quality. In the Philadelphia Metropolitan Area, where there are lots of hospitals and lots of health care services and lots of different catering services, I could envision having six or seven contracts for food service or six and seven contracts for engineering services.

But I wonder if there aren't some veterans' hospital facilities, nursing home facilities, ambulatory care facilities, or other kinds of VA medical facilities located in remote or rural areas or in areas that are less populated than a Philadelphia, Boston, or New York metropolitan area—which may have a difficult time coming up with enough competitive bids to make sure that the bottom line competitive bid not only is the best in terms of cost, but in terms of quality.

Mr. COOK. Mr. Edgar, that is undoubtedly true. Certainly we can anticipate that. One of the reasons that I say so was we had some limited experience where we have proposed to build some new activity that is a commercial—industrial type, we would make a review today.

And in half a dozen instances within the last 3 years we published a notice in the Commerce Business Daily; we had such an intent, and did not get enough responses for us to consider contracting out.

Mr. EDGAR. Thank you. I yield back my time.

The CHAIRMAN. Mr. Jim Dunn.

Mr. DUNN. I would like to make a statement. I don't have any questions, Mr. Chairman.

I have been sitting here listening to a bunch of cute remarks I am not sure that are germane; catsup and White House secretaries and airline food. I have always had a tough time understanding people, particularly in airlines who get on a multi-million-dollar aircraft and move several thousand miles, 200 people, through storms, weather, arrive within 1 minute of their destination, and their only comment is "my roast chicken was cold."

So, I don't think it is particularly germane to what we are talking about. I had been president of a company for 20 years which was involved in both contracting out- and in-house service.

I have seen contracting out work. My brother is a surgeon and has been involved in VA hospitals. He has seen contracting out work. I think we do a disservice to the veterans when this committee arbitrarily turns up its nose at any idea brought before us to provide the best, most-efficient service to the veterans of this country.

And I, for one, will be supporting any idea that goes toward those goals, and I thank you.

The CHAIRMAN. Thank you, Mr. Dunn. Any other comments from other members? Mr. McEwen?

Mr. MCEWEN. If I may, I would like to ask two questions. One, in your testimony, briefly, I know that this doesn't go to the heart of the matter, Mr. Cook, but you made reference to the fact that we

spend a great deal of moneys for ambulance and hired car services: $73 million.

In your opinion, if the VA had its own ambulances, could it save a lot of money?

Mr. COOK. No, sir. In some instances—it could. We contract for hired car and ambulance service where it is more economical to do so, but in more instances—and in most instances—we do contract for that service.

There are locations in the country where we have been unable to get satisfactory ambulance service; some cases we have run into situations where a community, a local government body had a monopoly on an ambulance service and dictated terms that we found unacceptable.

In those instances, we operate our own ambulance service.

Mr. MCEWEN. To get to the matter at hand, this circular was issued in 1979, and then in April of this year, there was an effort on the part of the OMB to encourage the VA to implement it with a little more vigor; is that correct?

Mr. COOK. Yes, sir.

Mr. MCEWEN. The VA then chose three areas, food preparation, hospital custodial care and/or maintenance, and plant maintenance. Is that correct?

Mr. COOK. No, sir, those three areas were suggested to us, proposed to us by the Office of Management and Budget.

Mr. MCEWEN. By OMB—and when the general counsel of the VA exempted the Department of Medicine and Surgery was that gratuitous or had it been recommended for contracting out as well?

Mr. COOK. The original directive, 1979, that came to us, contained examples of the kinds of services that might be contracted for. And notably among them were direct health care, physician care.

Mr. MCEWEN. So, general counsel of VA interpreted the circular as not applicable to the Department of Medicine and Surgery. As we have heard this morning, counsel for OMB has acceded to that, and in case we missed the base, the Veterans Disability Compensation Housing and Memorial Benefits Amendments of 1981 exempted the Department of Medicine and Surgery from this circular; is that correct?

Mr. COOK. The effect is to exempt it. The language of the bill itself does not say that. It says that funds from the medical accounts may not be used to conduct the studies under A-76. Funds and people.

Mr. MCEWEN. Fine.

In order to make sure that my thinking is correct on the three areas that we have remaining. Were they suggested from OMB as the initial areas to begin consideration of contracting?

Mr. COOK. Yes, sir. And probably—this is an assumption—because those three represent the largest single mass of employees of all the functions we have that are of a commercial-industrial type.

Mr. MCEWEN. Do you presume that if the recommendations of the studies had been implementation of private contracting for these areas next year that additional areas would have been added, or do you feel that this was basically the recommendation which——

Mr. COOK. No, sir, I am certain additional areas would be added.

Mr. MCEWEN. So as long as this circular exists, in your opinion, we will be holding such hearings, right?

Mr. COOK. Right.

Mr. MCEWEN. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Albert Lee Smith of Alabama.

Mr. ALBERT LEE SMITH. Mr. Cook, how scientific is the VA's estimate that it would require about $29 million to do the 4,000 studies in D.M. & S. as required by A-76?

Mr. COOK. It is not precise, of course, it couldn't be, Mr. Smith. But what we did was to study how long it would take to prepare one of these work statements and make the cost study. And we came up with, I think, 3 man-months of study, equivalent of three man-months of study. It is not three people; it is the number of people contributing time.

Mr. ALBERT LEE SMITH. Thank you, sir.

The CHAIRMAN. Thank you. I would like to thank our witnesses. If this A-76 circular doesn't go forward, I think it will be because this committee had some effect and brought attention to the area of contracting out. It seems to me that the present administration has broad authority and they are running the show. It is your responsibility where you see contracting out can do the job and save the taxpayers some money without harming needed programs to do so. I know you will move ahead on it with prudence.

I would like to ask the gentleman from Texas to take the chair now and as he comes forward to take the chair, I would like to call the next panel of witnesses and dismiss these witnesses. Thank you very much.

TESTIMONY OF A PANEL CONSISTING OF JOAN KERSHNER, DIRECTOR, VAMC, COLUMBIA, S.C.; WILLIAM H. KELLEHER, DIRECTOR, VAMC, WEST ROXBURY, MASS.; DR. MORRIS HARPER, CHIEF MEDICAL DIRECTOR, OUTPATIENT CLINIC, VAMC, BALTIMORE, MD.; AND DR. HOWARD GREEN, CHIEF OF STAFF, VAMC, WHITE RIVER JUNCTION, VT.

Mr. LEATH [presiding]. Our next witness will be a panel consisting of Joan Kershner, Director of the VA Medical Center in Columbia, S.C.; Dr. William Kelleher, Director of the VA Medical Center in West Roxbury, Mass.; Dr. Morris Harper, Chief Medical Director of the Outpatient Clinic Medical Center in Baltimore, and Dr. Howard Green, Chief of Staff of the VA Medical Center in White River Junction, Vt.

Dr. Kelleher isn't here.

Mrs. KERSHNER. I think he just stepped out.

Mr. LEATH. We are happy to welcome you, Mrs. Kershner, and you may proceed. I understand you don't have statements. We just will ask you questions.

Mrs. KERSHNER. Very good.

Mr. LEATH. I would like each member of the panel, please, to respond to this question. As the top executive in a VA Medical Center, what do you consider to be your most pressing concerns about OMB circular A-76 and the way it is being administered at this point by OMB?

Mrs. KERSHNER. Would you like me to begin?

Mr. LEATH. Mrs. Kershner, you may begin.

Mrs. KERSHNER. I think that from my standpoint, as Director at Columbia, S.C., the lack of flexibility is our greatest concern. Let me explain what I am talking about. We have a relatively new hospital, about 2 years old. We are affiliated with an emerging medical school.

We have had a hospital in that city for many years, and it has been a good one, but we have never offered specialties in medicine and psychiatry. It has 400 medical and surgical beds; 60 psych beds, and 120 nursing home-care beds.

In addition to that, we are responsible for a satellite clinic in the Greenville outpatient area, which is about 107 miles from us. We are administratively responsible for the Florence Cemetery; we are the clinic of jurisdiction for the State of South Carolina. We administer the fee prosthetics program for the State of South Carolina, and we do the laundry for the VA hospital in Charleston every day.

Now, this requires about $40 million for our budget. We receive it at the beginning of the fiscal year and skim off at the very beginning moneys to accommodate our salary needs, for our contract services; for certain line items in the budget. That leaves us about $3 million to administer for the rest of the hospital.

This past year, we had an assigned workload of 6,700 patients treated and 79,500 outpatients. We anticipated more than that. And even with careful screening of eligible veterans, we did see, in fact, 9,200 patients treated, and over 100,000 outpatients.

Now, I have no key to lock that hospital when our patient workload has been accomplished as assigned. Flexibility is the only key that I have. And how do I manage? Moneys are given to service chiefs at the beginning of the fiscal year as planned in our budget, and planned according to our workload.

When we exceed that, we have to withdraw funds from certain service chiefs to give to others.

For example, I may call the chief dietician and tell her that I would like her to maintain the nutrient value of the food served the patients, but reduce the kinds of food that she puts on menus as far as costs are concerned.

So she puts less costly foods on the menu and gives back to me certain dollars that I may then reassign to the pharmacy to accommodate the needs of patients as far as their drugs are concerned. And this goes on on a continual basis in order to provide as much care as possible to the veteran patient.

Our real concern is the care of the veteran. And we try to accommodate all those veterans who need that care, whether it is an assigned workload or not. We have a commitment to those veterans in South Carolina.

And so, to lose the flexibility, every time that we add a contract, we have to reserve those dollars, put them aside, to pay for the contract. If we had several contracts, our flexibility is no longer there. We must commit those dollars to the contract.

If we have additional patients come in that we did not contract for, we can amend that contract up to 25 percent. And then what? So the lack of flexibility is one of my greatest concerns. We are in

the South—not only do we have the additional services available, but we also have additional people coming into our area as well.

Mr. LEATH. Thank you for an excellent answer. As I understand what you are saying, I think most anyone will acknowledge that there is some degree of management flexibility that is lost when we contract, but I think what you are saying very loud and clear is that there is also a loss of fiscal flexibility.

Mrs. KERSHNER. Yes, sir, that is one of the greatest things.

Mr. LEATH. And I would assume that the bottomline would be that in the absence, oftentimes, of that fiscal flexibility on the part of those of you who are actually at the level of administering this care, instead of someone sitting up here in OMB and dreaming up how things could be done, that if the money isn't there, the care isn't going to be there.

Mrs. KERSHNER. Yes, sir.

Mr. LEATH. Mrs. Heckler?

Mrs. HECKLER. I think it was a very, very interesting perspective. Frankly, I think this insight is most unique, because I would not have imagined the difficulties that you actually face.

Do you presently have any services that are contracted out at your hospital?

Mrs. KERSHNER. Yes. We do. We contract for radiation therapy. We contract for CAT scans; we contract for elevator maintenance service and other maintenance service contracts that would be far too expensive for us to maintain personnel to do this who would have the expertise to do it.

Radiology; you are in deep trouble if you let anyone go into your radiology department and repair the radiology equipment without full and firm knowledge of how to do it.

Mrs. HECKLER. Most hospitals in the country would contract out radiology equipment repair.

Mrs. KERSHNER. In some instances they do not, but I think the majority probably do. We do.

Mrs. HECKLER. I would just like to ask one general question, which is what is your most pressing concern at the hospital?

Mrs. KERSHNER. How to take care of the volume of patients that we have with the limited funds, because our assigned workload is less than what I anticipate we will see this year, although we are just 2 or 3 weeks into the fiscal year.

There is a strong indication that the pattern will not change. As a matter of fact, before I came here I stopped by the eligibility department to see if we were having new patient applications or just the regular patients coming back. Our eligibility clerk told me that we had approximately 20 new patients present themselves each day.

Mrs. HECKLER. You have the long waiting room delays at your hospital?

Mrs. KERSHNER. We work at it very hard. Our longest delays are in pharmacy service.

Mr. LEATH. Any other members have any questions before the other three respond? Well, we are going to ask all four witnesses to respond to the same question. If you would like to——

Mr. MOTTL. Yes; thank you. Mr. Chairman, respective directors of your medical facility, do you presently have any outside contracting for any services now?

Mrs. KERSHNER. Services across the board, no. We do contract for certain services.

Mr. MOTTL. And have you had any bad experiences with those outside contractors? Can you relate those to the committee, if any?

Mrs. KERSHNER. Well, yes. In South Carolina, we have very few CAT scanners. In our particular area, we have one scanner for 14 counties. Recently, the regional health system agency approved another one in the Greenwood area.

If there is any downtime with this scanner, we then have to seek scanning capability for our patients in Augusta which is 70 miles away, or in Charleston which is approximately 100 miles away. So that we have had delays, we have had delays from the standpoint of return replies.

The readings have been as late as 10 days, so there has been some difficulty.

Mr. MOTTL. Will the others respond to that question? If you have outside contractors presently, have you had any bad experiences with your outside contractors?

Dr. HARPER. I just want to say that our situation is somewhat unique in that we are an outpatient clinic, a satellite clinic, a backup to the Veterans' Administration hospital in Baltimore.

We are located in the Federal Building, in downtown Baltimore. All of our services as far as maintenance is concerned are contracted out through GSA. So we have a Federal agency, GSA, which acts for us as in the building management operations of our facility. Most of our building services are then subcontracted out by GSA.

We have had a number of problems in terms of maintenance in our facility, in the areas of engineering services and heating and air-conditioning systems. These problems have existed for years.

We have on record a number of instances where we have submitted and justified our needs to GSA. GSA has sent representatives to the clinic to review our needs before contract bids have been requested. We can show a number of instances where it has taken 2 to 3 years to reach a position to let bids and get a contractor who will then act on the necessary work to be done.

We can also show that in a number of these instances, the work did not meet the standards specified by the contract. We can also show that the cost that was estimated and approved by the GSA for the work is higher by the time the contractor actually does it.

The cost 2 years hence, in many instances, is much higher than what it was originally agreed upon. We then have to go back into a renegotiation, either reassess the project or decide to delay it, redo it or be prepared to go back into the Central Office, or the hospital, depending on the cost of the project, and ask for additional funds.

Also, we are ofttimes limited by what we can do if we chose to do the work ourselves. Currently, we are unable to paint walls within the facility in which we operate; we are unable to do any of the maintenance work.

We have estimated in some instances, not all, that the work could be done in a timely fashion by the hospital engineering

department. The department has said that they are in a position to do the work and have the manpower to do it. They could even allocate a small portion of the funds with which to do it.

We are hampered, however, by a host of bureaucratic procedures. For example, we have been told that the subcontractors could retaliate as part of the agreement for the maintenance operations of the Federal Building, that it would be a violation of the contract to bring hospital staff in to do any of this work.

So there are a host of things that we have contended with for a period of 3 years. It takes an awful lot of work, man-hours, time, and renegotiation to get what appeared to be very simple things done. Had we had an in-house capability to do this work, we could have completed it probably within 1 month, 6 months maximum.

Mr. MOTTL. So, Dr. Harper, your experiences have not been good with outside contractors; is that correct?

Dr. HARPER. That has been my experience in those instances where we have a contractor do the work. Usually a contractor is tied up by other limitations or obligations.

We have been successful in those instances wherein contractors have had the obligation or the time commitments. When there are problems, that he or she is unable to handle, we feel we are in a position where we are somewhat hamstrung.

There is nothing we can do. The process itself does not allow us to take the necessary action without worrying about the legalities involved. If we intervene or interfere we may be held in violation of the contract. Therefore, the Veterans' Administration may be held liable. So it is these kinds of barriers that keep us at a standstill.

Mr. MOTTL. Thank you, Dr. Harper.

Dr. Kelleher, I mean, Mr. Kelleher, have you had any outside contracting experiences, and what have they been?

Mr. KELLEHER. My experiences have been similar to Dr. Harper's in two instances. I was the director at the Boston Outpatient Clinic, which is similar to his, only quite a bit larger.

I think our experience could be characterized under a term that I call sense of urgency. I find some of our contractors don't have the same need to deliver service with the same degree of urgency that we believe we should have.

We had elevator contracts, both for construction and repair at that facility. And even where I am now, at West Roxbury Medical Center, we have similar problems with repair of elevators with our contractors.

We also had the same at the outpatient clinic with the cleaning contract. I believe that some of our contractors face problems in these times of tough economics with inventory management. In particular, in our hospital right now, we have a generator in one of our elevators which has needed repair or replacement, for somewhat close to a year. The contractor has felt the need to build a generator for us, rather than have them in inventory which I can understand in part, but it doesn't help our elevator system.

Mr. MOTTL. So your experiences have not been good, either?

Mr. KELLEHER. In those areas, not good at all.

Mr. MOTTL. Dr. Green, my last question, Mr. Chairman, Dr. Green, what if the outside contractor that you would hire would strike; what would you do then? Or any of you on the panel?

Dr. GREEN. Well, that is a real potential problem. Regardless of any strike plan that you might develop, I think it is naive to assume that a contractor can necessarily deliver, in spite of a strike plan.

What you would have to do, since you are stuck with sick people, for whom you have a legal and moral responsibility, is do the job yourself. And the question is who would you then lean on to do it? The largest single service in any hospital, and probably one of the key services, is the nursing service. You are all aware of the problems that we are having in staffing our hospitals.

Many of our hospitals have closed wards because of lack of nurses. The nurses, as a group, are questioning what their role in a hospital is, and are becoming more vociferous about their professionalism.

To then move to load those duties upon the nursing staff would probably be the straw that broke the camel's back. In essence, we would have tc do like every group does under stress, we would just have to pull a load and do it. But I am not sure that that would be to the advantage of our patients or to the advantage of our hard-worked staffs.

We are operating right on the edge now, sir, in our ability to deliver hospital care. The pressures on us are tremendous.

Mrs. Kershner's statement about management flexibility and the ability to do what we have to do to do the job I think is as good a statement as I have heard.

Mr. LEATH. Mr. Edgar?

Mr. EDGAR. Thank you, Mr. Chairman. I just have two areas of questioning. I wonder if each of the witnesses might talk about the morale in the hospital as a result of A-76.

Dr. GREEN. I can lead off with that, sir.

There is a great deal of anxiety in the hospital right now, particularly among our food service workers and our housekeeping people. From the perspective of a physician, they are a part of our patient care team, and I can enlarge on that later, if you ask a question.

But morale is going to pot. And people are becoming consumed with worries about their jobs, and about what this all is going to mean, particularly in a rural environment where the flexibility to go someplace else locally for a job at anywhere near the rate of pay is very limited.

We have severe morale problems, not only over A-76, but over the whole budgetary process in general in the squeeze that is on us. It is probably necessary, but morale is terrible.

Mr. KELLEHER. Our experience in the Boston area is very similar. In fact, it is not only affecting the building management employee and the food service workers, but also affecting the top staff within those services. They are afraid of transfers; they don't know what their management responsibilities will entail in meeting situations which Dr. Green referred to as strike potential.

Mr. EDGAR. If I may ask a question there. With the high interest rates and the difficulty of mobility in our society, with some of

those higher level administrative people, are they nervous about lifting their family up from one part of the country and moving to another with interest rates at 18 to 20 percent?

Mr. KELLEHER. I have heard some of them refer to it as a financial disaster. Our system doesn't compensate people adequately.

Mr. EDGAR. Thank you.

Mrs. KERSHNER. In our facility, we are no different than anyone else, as you would be, if suddenly your job was in jeopardy. It is demoralizing——

Mr. EDGAR. If the gentlewoman would yield, my job is always in jeopardy in my district.

Mrs. KERSHNER. Well, you know how nervous you feel. And the thing that is the most interesting is we have had a very heavy workload, and they have been very proud of the work that they have been able to accomplish with the same number of personnel. They think they have done a wonderful job. They just are stunned to think that suddenly, as hard as they have worked, and as proud as they are about their accomplishments, that that doesn't do them any good. That good work doesn't have any impact.

It doesn't make any difference whether you work well or ill. And suddenly, they take a step back and look at what they have done, and wonder if it is worth it. We must continue to take care of the patients and to encourage employees to do the best job they can. Possibly they will win out, and have the contract awarded to them.

Dr. HARPER. I would just like to say that in our facility, the concerns are very similar to the concerns that have been mentioned so far. I think in addition to that, at the top levels of it there is a serious concern that we have to contract in other areas. That it will become next to impossible to do a good quality job in terms of health care delivery.

In those instances where we have in-house capability, during good times we can do the job. In bad times, we can encourage the troops, we can gather around, we can support each other, we have a team spirit.

In those instances where we do not have the control in terms of in-house capability, we are totally in a situation wherein regardless of how great the need may be or how committed we may be in terms of meeting that need, we just do not have the capability to do it. And people who are not a part of our team process, are not there on a day-to-day basis, understanding the ripple effect it is going to have on the other people, somehow cannot really share in that process.

And these are the strong concerns we have.

Mr. EDGAR. In the interest of time, I am not going to ask each of you to respond to this, but there have been a number of alleged curtesy comments and questions and substantive comments and questions made of earlier witnesses.

Do any of you have any comment that you would like to make to any of the lines of questioning that were raised earlier from other Members of Congress who may have had to leave for other responsibilities?

Dr. GREEN. I think one of the central issues is what represents a therapeutic care team. And I feel very strongly as a physician that

88-005 O--82——4

the building management people on the wards adapt to that ward and work many times outside of their "statement of work" or job description. This is one of the things that keeps the system afloat.

I find it very difficult to conceive of developing a statement of work for chaplains. The whole issue of the ethical basis of medicine and the role of the chaplain is coming into focus, particularly in our cancer wards.

I, quite frankly, have been appalled to think that people would fall into what I call the fallacy of misplaced concreteness. The dieticians, the people who deliver the food, the food service workers if management is heads up at all, are part of that therapeutic team, and I think you have to recongnize this. I don't think you can quantitate it with numbers.

Mrs. KERSHNER. I agree very much. There are, certainly, good contractors in the market. And there is no question about that. But, most everyone has watched MASH. And when the team goes into action, you depend heavily on each other. As contracts fragment the hospital, you lose that same viability and team spirit. And you just don't do as good a job.

Mr. KELLEHER. I just have one comment, Mr. Edgar. I think it is incumbant upon us to clarify the statement of work. In my opinion, that is really no different than specifications which we have used for years in contracting. We are drawing it probably more precisely. There really isn't very much difference.

Mr. EDGAR. Thank you very much for your questions. I yield back my time.

Mr. LEATH. Mrs. Heckler, do have any questions?

Mrs. HECKLER. I would just like to ask Mr. Kelleher one question which is, have we had any cutbacks, have you had cutbacks in the West Roxbury Hospital? In general, are there any people who have lost their jobs recently?

Mr. KELLEHER. I can't say anyone in specific, in particular. However, our budget for this year, fiscal year 1982, has caused us to reduce 15 positions. We will be doing that by attrition and various other means.

Mrs. HECKLER. How many employees are there at the hospital?

Mr. KELLEHER. 800, totally there are something like 927, but that includes part-time, intermittent, and so forth. Our regular FTE, what I call regular, according to ceiling, is 780.

Mrs. HECKLER. Thank you.

Mr. LEATH. Mr. Daschle? Do you have any questions?

Mr. DASCHLE. Mr. Chairman, I don't have any questions at this time.

Mr. LEATH. Thank you very much, we appreciate your very excellent response to the questions and your contribution to what the committee is seeking.

Mr. LEATH. At this point, we would like to make a slight change in the schedule, due to a transportation problem of the two witnesses involved.

I would like to ask Dr. Richard Schmidt and Dr. Richard Ryan, if they would come forth at this time, and we will just slide everybody up a slot since these gentlemen have to catch a plane rather quickly.

Dr. SCHMIDT. To go back to snow country.

Mr. LEATH. Gentlemen, if you would, I would like to ask you to summarize any remarks that you want to make, and then allow the members of the committee to respond with whatever questions they might have in the interest of time.

STATEMENT OF DR. RICHARD P. SCHMIDT, CHAIRMAN, SPECIAL MEDICAL ADVISORY GROUP TO THE VETERANS' ADMINISTRATION

Dr. SCHMIDT. I have listened to the testimony this morning rather carefully, and I can see the concern of this committee on the implementation of A-76 in such a large system as the Veterans' Administration.

Indeed, just before coming up here, Dr. Ryan and I chatted momentarily about why is this applicable to the VA when it has already been extensively engaged in contracting out. It might even do so more where it does make sense, both in the provision of better services and in the saving of money and increasing the efficiency.

I don't know who the sage was who said it, but one of my favorite expressions is, "If it ain't broke, don't fix it." And I think we have an example of that here in a rather large amount.

There are difficulties, as I see them, in extensively contracting for certain kinds of services, to have people working with similar levels of responsibility working next to each other, who may be subject to different benefit programs, different salary programs.

If I think of comparable level of employees in a hospital, for example, one might be food service. The other might be the janitorial service; it might be in the same general pay range. One is working for a private entrepreneur with an entirely different system of reimbursement, rights, and so forth. Maybe an entirely different union. The other group working either, for another private group or for the institution itself.

I am responsible for the administration of an academic health center, being president of State University's Upstate Medical Center in Syracuse. We have 2,700 employees. We do have contracts, some of which work extremely well.

We have one contract which has worked well, off and on, and has worked poorly off and on, with change in contractors, which is one of the big problems. Not too long ago, we had to rebid our food services contracts because of State regulations. The company is a large and very well-managed company of the United States, with multiple enterprises. The people who prepared the bid, grossly underbid.

They then were forced first to try to cut down on their expenses and their losses. We had to hold their noses to the grindstone, at least to the letter of the law of the contract. Then, according to the escape clauses, they withdrew and we had to go out and rebuild again.

It creates a problem in a reasonable operation of an institution having this type of thing happen. I would think that the Veterans' Administration has done a very good job of contracting out. It might be given more flexibility to do more contracting, but I am frightened by A-76, per se, and mandating things that might be contracted—for many of the reasons I have heard both from the

members of the committee and from the witnesses this morning. Thank you.

Mr. LEATH. Thank you, Dr. Schmidt, for an excellent statement. Dr. Ryan?

STATEMENT OF DR. RICHARD M. RYAN, DISABLED VETERANS REPRESENTATIVE IN THE SPECIAL MEDICAL ADVISORY GROUP TO THE VETERANS' ADMINISTRATION

Dr. RYAN. I wish to support the statement of Dr. Richard Schmidt, and also to recognize the fact that in addition to the $700 million contracting out money we are now talking about the possibility of an additional $400 million-plus, which would be contracted out involving the three services discussed here today.

There comes a point in the management of a national health care system when the contracting out dimensions begin to limit in a very significant way the strategies which can be developed for delivering health care. And I think that that is one of the central issues in examining A–76.

We are basically talking about 18 percent of the D.M. & S. budget being contracted out. OMB cited an article in which 4,000-plus contracts existed across the country in contracting out by various health care facilities.

I think that is probably an understatement. I am sure contracting out is much more prevalent. However, I don't know of any hospital in the voluntary sector that contracts out 18 percent of its support services and key departments in the provision of care. Dr. Howard Green made the comment that the team includes dietetics and various other workers beyond the nurse and the physician.

We are not talking only about the nurse and the physician. I really do think that the autonomy of that team, and the integrity of the system requires us to look very carefully at what is being proposed in A–76. I am very much concerned by the fact that once you contract out to a small business organization, you cannot recall that contract, you cannot even look at the feasibility of providing that service within the VA facility again.

It is not a revolving door. The options that we have in the management of private sector hospitals permits one to measure the efficiency or inefficiency of the operation and to selectively contract out. If we don't like the contract, we can back out of it. I don't see that kind of option here. Therefore, I see a constraint to the management of the system. I believe we are all interested in one thing and that's the bottom line. What counts most here is not cost effectiveness. It is the efficacy of care for the veteran in this country. We must keep our eye on that because I think we are about to compromise the efficacy of providing high-quality care to the veterans.

I would like to answer your questions at this point.

Mr. LEATH. Thank you, Dr. Ryan. I want to compliment both of you. I think you have really moved to the heart of the problem as most of us see it. And we appreciate that. Mrs. Heckler?

Mrs. HECKLER. I would agree with the chairman that, really, you both made an excellent presentation. It seems to me that what we are faced with is the new strategy on the part of those who really would like to dismantle the veterans' medical system.

Earlier, there was such a proposal, and there was backup from the National Academy of Sciences and there was a frontal reaction by the Congress in support of the system. So, what cannot be done directly is now attempted indirectly.

What we are seeing now is a nibbling away of functions which then cripple the administrative flexibility and ultimately we will be left with the situation in which a few skeletal functions will be essentially performed by the VA staff, and those then can be transfered to someone else, and the question will be made, if we have contracted out all of the services, virtually from the top and the bottom, and leaving that middle range with difficulties within it; the nursing shortage being a major difficulty.

Then why not simply allow the veteran a special allotment on a national health system program, rather than preserving an independent health care system? I really feel, personally, that the long-range problems are that the short-range economy is a very, I think, inappropriate economy in the sense that you have the strike potential, you have the problems of finding quality contractors all over the country at the 172 hospital locations.

It seems to me that this is just another way to get at the grand strategy which is really to remove the veterans' medical system. Now, would you agree with that, Dr. Ryan?

Dr. RYAN. Well, I think that that very clearly is the threat here, that incrementally, what we have had to do over the past several years is to reduce our staffing and convert physicians into dollars which can provide the kind of support which is required to provide medical care.

We paid a very high cost for maintaining the outpatient volume and the in-patient volume that we currently have in the system. We are now at a point of marginality in staffing, below which is disaster. And my concern is that the quality of care is going to suffer considerably in the system as we begin to limit the options available to the administrators.

In testimony before the House Appropriations Committee this past year I indicated that micromanagement is constraining the VA in such a significant way that administrators can no longer manage this system. They are being limited everywhere they turn.

A-76, as I look at it, as a planner, a hospital administrator and academic administrator, is one more constraint in that direction.

Mrs. HECKLER. Well, Doctor, you have had an excellent—you have had an outstanding record, both with the Veterans' Administration and with Harvard University. I, personally, have one other fear, and that is that the quality will diminish so badly that we will be preserving only the skeleton, and then we will not be serving the veteran either.

I think that we are not at the point of that serious reduction in force that the quality is presently jeopardized. But if we proceed to reduce the budget 15 percent each year, we can, in a very short time, reach the point where we will have a medical service in name only and not in quality. Is that one of your concerns, and what would you recommend to the Congress to avoid such a possibility?

Dr. RYAN. Congresswoman Heckler I really feel that when you constrain $1.6 billion out of an estimated $7 billion budget for

DM&S, and tie it up in both title 38 decreed contracting and the A–76 contracting, we will have so constrained that system in terms of the management options that it is going to need some radical surgery.

I think that with the decremental budget the VA has had over the past several years, which has not kept up with inflation, and now these constraints, that we are going to have to look squarely at the system and ask how we are going to meet those increasing demands of an aging veteran population; of the agent orange eligibles; of various other categories of veterans who now require care in the system.

Current health care services demand exceeds VA resources. We just have to recognize that. I am not quite so optimistic as you are that we have not reached that point where our ceiling and our resources are inadequate. They are now inadequate to meet the demands. The VA is controlling demand in its system, I believe that by imposing the kinds of constraints, proposed in A–76, we are using a defective management instrument, and that is my major criticism.

By imposing these constraints indiscriminately we are dealing another very serious blow to the Veterans' Administration system.

This past year I visited a number of military hospitals on the west coast in which I saw why they were contracting out specific kinds of services. I believe it was because they did not have the personnel to maintain and to provide quality service. I am sure that in desperation one might find that that the VA could be in exactly the same kind of a position. I would urge you to do everything in your power to see that we not go in that direction.

Mrs. HECKLER. I would agree with you.

Dr. Schmidt?

Dr. SCHMIDT. Yes, I agree very much with Dr. Ryan. I think the system is fragile and on the edge. Money is not being spent for maintenance of the system, nor of the capital that it possesses, and it will create further debts later on as deterioration occurs.

I think already one can see—I do not work for the Veterans' Administration—but already one can see, through news items in the papers, increasing limitations upon the access to the system for the veteran, for whom this Congress of our country have indicated this is a debt, a reward, a concern on the part of our Nation to the person who has served his country.

And I think access is being very much limited, and will be more limited in the future, especially as increasing workload is added in terms of expanding eligibility, but not reducing the eligibility in another point. I think we can speak of—Dr. Ryan mentioned the agent orange—we can speak of, also, people who are my age, above and below, namely, 60 or above, and to see the expanded eligibility without the concommitant increase in resources to provide comprehensive care, which is the kind of care which should be given to everybody who gets it.

Mrs. HECKLER. Thank you, Dr. Schmidt.

Mr. LEATH. Mr. Edgar?

Mr. EDGAR. Thank you, Mr. Chairman. I think almost all the questions have been raised on this issue, and I don't want to prolong the discussion and you do have a plane to catch.

One question I did ask earlier about the regional differences and the ability to contract certain services. I wonder if you would just briefly comment on that issue.

Dr. SCHMIDT. I think the differences would be very great. I suspect one could get a contract to do anything. And I think there are many very fine contractors which are spreading nationally. I think it would be far different, for example, in a community the size of White River Junction, that it is a community—even our small community of Syracuse, which, by comparison, is a large metropolitan area—or comparing the small community of Syracuse to large metropolitan area such as Boston, New York City or Los Angeles.

We have heard comments this morning of the economic impact or the potential economic impact—the impact on individuals who may be approaching retirement. Those who do not have complete vestment, they have almost complete vestment, who are not mobile.

I think it would make a great deal of difference as to the geographic area, and I would suspect very strongly that if one were to study the existing contracts, we would see differences by geographic area on the things which are contracted out.

Everything from the window washing in a building 4 stories high, I would suspect would be very much different from the window washing in a building 18 stories high, where you would need much more different kinds of special equipment and specially-trained people, and the one is in a big metropolitan area and the other is somewhere else.

Dr. RYAN. Mr. Edgar, I think that the one thing that should concern us about this morning's testimony in relation to your question about regionalization is that now we are in a situation where we cannot really study that question. If we don't have the $30 million that is required to conduct the kinds of impact analyses, et cetera, which you and I, as a planner and administrator, would require, then I ask how are we going to find the solutions?

I think we have come to an impasse on that one and that is an issue which needs to be resolved immediately. And I know that you are as concerned about that as I am, because a first premise in planning and in philosophy is that you don't give what you don't have. And without those resources, I don't see how we can resolve the dilemma that we have before us.

Mr. EDGAR. Thank you. That was helpful.

Mrs. HECKLER. I want to be absolutely clear that I understand what you are saying, Dr. Ryan, you are saying that we should grant the resources to determine whether or not this approach is worthwhile?

Dr. RYAN. I think that management always has to have those options, Congresswoman Heckler, to examine the impact of various new initiatives. It costs money to get those answers. If we can't get that money out of medical care, then where will it come from?

I suggest that there are some questions that have to be asked about the feasibility and desirability of specific or general applications of A-76. We don't have those answers, and without those answers, I, as an adviser to the Chief Medical Director, clearly could not recommend that the VA go down the path of universal contracting out.

Surely the professional manager is going to want to ask what kind of economic impact is involved and what are the issues here? Hopefully he will be able to resolve those questions.

Mrs. HECKLER. Well, I think that Dr. Schmidt gave us the answer, if it ain't broke, don't fix it. Now, really, are there problems in these areas? We haven't had testimony to indicate that these are the areas of problems within the system. Why invest another $30 million to study a problem that doesn't exist, and create a new one?

So I would think that there are serious questions to be asked about the VA system, and about improving the quality of care within the budget restraints. But I really think we are directing the questions to the wrong subject matter.

Mr. EDGAR. If I could just return to some of my time. Dr. Ryan, in your answer, I understood, that unless there is some planning and study money, that we ought not to proceed. There is a subquestion there, too. And that is, whether or not that planning and study money ought to come out of administrative budgets, or whether it ought to come out of the medical budgets of the hospital system.

Do you have any comment on that, where the budget line items should be if we provide those funds?

Dr. RYAN. If we are talking about existing moneys in either case, we are talking about another serious undercutting of scarce resources, whether we are talking about administration funds or medical care funds. If we are required to conduct studies and to justify A-76 application, which I think we are rationally, the only way I know that you could do that is through some supplemental appropriations.

And I am sure that that is objectionable as well. I am not suggesting that you take it out of the current VA budget. I would agree that Dr. Schmidt's comment about there not really being a serious problem here is accurate. I believe that the evidence does not exist to indicate that there is a serious problem.

Mr. LEATH. Thank you. Your testimony has been extremely helpful, and we appreciate your coming.

Dr. SCHMIDT. Thank you very much. It is good to have a Texan in the chair, since my daughter is a Texan.

Mr. LEATH. Thank you.

While the next panel is getting ready I would like to ask my colleague from Texas, the Honorable Henry B. Gonzalez, to come forth. Henry, we are delighted to have you this morning, and if you are to make what comments you might have on your mind, we will be happy to put your entire statement in the record.[1]

TESTIMONY OF HON. HENRY B. GONZALEZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GONZALEZ. Thank you very much, Mr. Chairman.

Yes, I will accept that offer and thank the subcommittee as well, and the counsel and all who have been very helpful. I come from the area that is served by the Audie Murphy Veterans Hospital, the newest, and in my opinion about the finest anywhere, but particularly in the Southwest.

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[1] See p. 91.

I made that a priority when I first came to the Congress in 1962, argued for it successfully, with President Kennedy and then fought for its authorization, and for its appropriation. I am responsible for the naming of it after a genuine authentic American hero, a fellow Texan, Audie Murphy, and worked along with the great former chairman of this committee, and also a Texan, the great "Tiger" Teague, whose help, almost singlehandedly, made it possible to eventually reach the stage of construction, the only hospital built during a similar period of budgetary austerity, which, incidentally, is what we are hearing about today.

I just briefly want to say I feel this A-76 procedure is predicated on just one main thing, and that is to skin the employee in the VA system. And whatever the budgetary pressures are we should not do that, and I am very glad to see that this committee is reviewing the whole matter and has given this much priority and attention to it.

If indeed and in fact the savings that are argued in behalf of this system are true, then the administration ought to make a case for it to show that it genuinely will save.

Studies that we have made indicate that there will not be any savings.

And second, that if the idea is that the schedule of pay and compensation are not current and what we established is not proper, then the administration ought to come in frontally and present its case on that, not through the backdoor of this A-76 contracting-out scheme.

I would at this point like to enter the prepared text of my remarks.

And, once again, thank you for the chance and opportunity to be heard.

Mr. LEATH. Henry, we appreciate your coming, and we appreciate your statement.

Your history of support for the veterans' health care system, as you have pointed out, is long and strong, and I take a great deal of pride as a fellow Texan in the fact that you and "Tiger" Teague and Ray Roberts and a great many from our delegation, along with this fine committee, have been concerned about this for a long time. This is not a new battle.

Mr. GONZALEZ. That is right.

Mr. LEATH. As you have pointed out, it seems that there is somebody in OMB who is intent on, one way or another, attempting to shut down this system, so we appreciate very much your statement and your interest.

Mr. GONZALEZ. Thank you.

Mr. LEATH. Mr. Edgar, do you have any questions?

Mr. EDGAR. I do not have any questions. I just want to thank you for coming.

Mr. GONZALEZ. Thank you, Congressman.

Mr. LEATH. Our next panel will be Miss Yvonne Moody, Director of Nursing Service at the Medical Center in Minneapolis, Ms. Mary Helen McGuire, Chief, Dietetic Service, the Medical Center in the District, and Mr. Jesse P. Cleveland, Chief, Building Management Service at the VA Medical Center in Washington, D.C., and Mr.

Neil McBride, Chief, Engineering Service, of the VA Medical Center in Cleveland, Ohio.

Ladies and gentlemen, welcome. We appreciate your being here this morning. In the interest of time please attempt to be as brief as possible, although we do want you to respond in a complete manner.

We will start by posing a question to Ms. McGuire.

In your personal experience or in your professional contacts with your associates in the dietetic field, have you found that private-sector contractors are interested in providing total services or management services?

TESTIMONY OF A PANEL CONSISTING OF YVONNE MOODY, DIRECTOR OF NURSING SERVICE, VA MEDICAL CENTER, MINNEAPOLIS, MINN.; MARY HELEN McGUIRE, CHIEF, DIETETIC SERVICE, VA MEDICAL CENTER, WASHINGTON, D.C.; JESSE P. CLEVELAND, CHIEF, BUILDING MANAGEMENT SERVICE, VA MEDICAL CENTER, WASHINGTON, D.C.; AND NEIL McBRIDE, CHIEF, ENGINEERING SERVICE, VA MEDICAL CENTER, CLEVELAND, OHIO

Ms. McGUIRE. In doing a survey of the local Washington area and talking with friends about the country, contractors are interested in management only. They feel that the employee is more worry than worth.

Mr. LEATH. Miss Moody, I would like to direct this question to you, please.

As Director of the Nursing Service in the studies that you have been directed to conduct by OMB have you encountered any contracting situations which would result in increased workloads for nurses, and how would this affect the nursing service, as you see it?

In VA hospitals, 900 beds have already been closed, as you are well aware, as we are, because of nursing shortages, and certainly that shortage exists in the private sector as well.

Would increased workloads multiply any recruiting and retention difficulties that you are experiencing already in a short market? It is our understanding that nurses are presently leaving the VA system in substantial numbers, and surely increased workloads are going to cause them to sit back and take further looks at a career with the Veterans' Administration.

I guess the bottom line would be to just give us your thoughts on the effect of this initiative on your recruiting, your retention, your morale, and so forth.

Miss MOODY. In general I think we have to be concerned with our overall capabilities of support services that VA currently offers.

We are currently without a full range of supportive services to meet our current workload and the needs of our current patient population. It seems then to contract out a service that is already deficient in terms of what it is able to provide to the direct care arena seems likely to lead to chaos, a chaotic situation that I am certain we are not ready to really have to deal with.

In terms of its impact on nursing service I am certain that if there is a disruption in service, it will be the nursing service

employees who would be called upon to respond and accomplish those needed duties.

You are quite right, sir, when you say we have a national shortage of nurses. The VA is not the most attractive alternative that RN's look to when they are seeking employment. The added workload of providing services that should be provided more appropriately by others would be another factor in making us less attractive. It is currently a factor, so it would be even greater.

The possibility of disruption of services I think has to be addressed. It is very real. If that does occur, again we know nurses are so very close to the bedside that we indeed would be those individuals who would perform those other duties.

So what we are saying is we would pass the trays, we would empty the garbage, we would clean the floors, and if those nurses then had time left we would provide direct care.

I think then what we would see is the quality of our care reduced and our capabilities of providing direct care diluted. We must remember nurses do go in the profession to nurse. I believe we would see then in great numbers many nurses leaving the VA system. As it is now, it is so difficult for us to compete with the outside world in the recruiting and retention of nurses.

Thank you.

Mr. LEATH. Thank you, Miss Moody. I have some other questions I would like to ask you later on, as I am sure Mr. Edgar does, but let us start with you, Bob, and move on through the other two members of the panel.

Mr. Cleveland, how has the A-76 study efforts affected the performance of building maintenance employees up to this stage of the implementation process, and what do you determine the future impact on employee performance up to the completion of the cost comparison studies if they are allowed to go forward?

Mr. CLEVELAND. I think what has happened so far is that the morale is very low. This has been discussed before. I think it is going to decrease even further in the next few months, without this bill just signed.

I think it is going to improve now, for approximately a year, sir. If A-76 comes back into vogue we are going to go up and down this escalator again, and we are going to have difficulties.

I think that if we go to a cost analysis or to a cost study, regardless of whether we contract out or stay in-house, the services will deteriorate to some extent.

I say this because we are in the business and will compete with a private contractor who is going to cut corners. He is going to do what he has to do within a certain amount of funds. If we compete one on one with him we are going to reduce services. I am afraid because of this reduction in service, our cost analysis will show a smaller cost than what it actually costs, and I am afraid the OMB is going to get hold of this A-76 cost comparison study and in turn use this against us for future budgetary limitations.

So I can see an impact of many, many years, as long as A-76 is invoked.

Mr. LEATH. I totally agree with you.

Mr. McBride, the VA's medical facilities are aging rapidly, as has been mentioned by some of the witnesses this morning, and of

course many members of this committee are very much aware that maintaining the hospital physical plant has got to be one of our most important functions as we go through this critical decade and the years ahead. As a professional engineer, do you believe that contractors will be able to maintain the VA facilities in an acceptable fashion?

This committee has been informed that the D.M. & S. Engineering Service already contracts for a substantial amount of A–76-type services, such as equipment repair and various forms of maintenance. Could you estimate for the committee the annual dollars expended with private-sector firms at the VA Medical Center in Cleveland for these purposes?

The committee would also appreciate your describing an example of the specific work accomplished by the contracts with private firms.

Mr. McBRIDE. Certainly. At the VA Medical Center in Cleveland I have a recurring M. & R. budget of approximately $1 million. Of this $1 million, there is about 43 percent that is spent in the contracting area. We do total elevator maintenance by contract. We do quite a bit of work in our boiler plant by contract.

For office equipment, including typewriters, we spend in the neighborhood of 14 percent of that $1 million.

Electrical maintenance, in the high-voltage maintenance, we go out to contractors to do this type maintenance.

In our medical equipment repair areas, which is direct patient care, we do approximately 50 percent of all our maintenance through contract.

Of great concern is the quality of maintenance that we would get if we went A–76 due to the fact that our wages are determined by the localities in which our medical centers are located.

If the contractors are going to underbid us, they are going to be paying lower wages. By paying lower wages, since we are compatible with the rest of the community, it appears that the quality of people they will be able to hire will be somewhat lower than what we are accustomed to employing.

This will, even though we have our work statement, which has quality work requirements, be a management burden on our staff to try to administer these contracts.

It appears that after the initial go-arounds, we will be back to fighting for our employees to get them back on the rolls.

The morale of the people in our facility now is very low, or has been. Because of this we have to consider that in the hospital one of our greatest concerns is how do we handle emergencies with the less quality employees, if this is what the contractor would provide us? How do we handle many of these emergencies—where now our employees feel that this is part of their responsibility, and they are very loyal to us?

I think this can be demonstrated though, if we look at any natural disaster that has occurred at any medical facility across the country, VA employees have stepped in and protected both property and most importantly, the lives of our patients and our employees.

Mr. LEATH. Thank you.

Mr. Edgar.

Mr. EDGAR. Thank you.

I was impressed with all of your comments about the question relating to morale. I think I heard from everyone the nervousness about the A-76 regulations, is that correct?

I had a tour of the Philadelphia Veterans' Hospital recently, and I walked around with the engineer, and Mr. McBride, I think he holds the same position that you do——

Mr. MCBRIDE. Yes, he does.

Mr. EDGAR [continuing]. At the hospital.

As we were walking outside the building he pointed out some individual air-conditioning units that were in individual rooms on the fourth or fifth floor. He told me an interesting story. He said one day the compressor that related to the air-conditioning system went down and we were faced with the immediate need of trying to get it operating again because it was in the summer months. We had one section of the building which was not air-conditioned and we had patients in that particular facility.

This happened on a Friday. On Monday morning there were a number of individual air-conditioning units put in the ward section of the hospital. Evidently about a third of the hospital's air-conditioning efficiency was taken out, but this replacement of these individual units was able to make up for that third.

Eventually the hospital engineering staff discovered that the individual units placed in the wards were more efficient than the old hospital system. They eventually did not go back to bringing the whole cooling system back up to speed.

But the correction was made by a quick-thinking, fast-on-his-feet engineer who saw it as an immediate problem for patients and patient care in that hospital. It was not done by going out and contracting on competitive bid. It was done by some commonsense techniques. It is still in place, it is still working, and in fact providing better air-conditioning service for this particular wing of the hospital than was provided before.

Is not that a problem with having too rigid a contracting proposal system in place, that the ability for the local engineers and maintenance people who, if this proposal goes through, may not even be in place to respond to that kind of quick turnaround and quick efficiency in the hospital center?

Mr. MCBRIDE. I think there is no question about it, that it would be difficult to get a contractor to respond as quickly as we are able to muster our people.

Mr. EDGAR. I guess I was impressed by the efficiency of this particular engineer who just had the sense, that if it needs fixing let's fix it. Let's see if we have the expertise here. He's not afraid to go out on competitive bids or contracts if there is time and if there is an ability to do it, and if it can be done at lower cost, fine, but his feeling was that the rigidity of this particular circular would mean he would have to lay off many of his people who could in fact respond and solve many of the emergency needs of the hospital in a more efficient way than any kind of contractual relationship could do.

Mr. LEATH. Would the gentleman yield?

Mr. EDGAR. I yield to the gentleman.

Mr. LEATH. Bob, I think that is an interesting point. I am glad you brought it up, and Mr. McBride might care to comment on it.

I think when you look at the VA system as a whole that their record of conservation and energy saving has, I think, exceeded any agency in the Government, and I think the engineering people in the VA are to be commended for not only the incident that Congressman Edgar points out, but throughout the entire system.

Mr. MCBRIDE. I think we are just starting with our savings in energy. The VA Medical Center at Cleveland, for example, has approximately a 10-percent reduction since 1976. Our 5-year plan, through fiscal year 1985, will call for approximately another 30 percent, which in today's dollars amounts to approximately a million dollars out of a $2½ million utility budget that I manage at Cleveland.

Mr. EDGAR. And just finally, Miss Moody, you were very articulate in your comment about the morale problems among nursing personnel if we had to get involved in the contracting out, and I wonder if you could just reemphasize your statement there so that the record is clear about the feelings of persons like yourself on this particular subject.

Miss MOODY. Yes. The greatest problem for nursing services today, not just the VA, but nursing throughout, is the recruitment and retention of registered nurses primarily.

I see then our entering into such activities as the contracting of supporting services which already are deficient as one of the greatest problems that could further deter our abilities to free that nurse to provide and be able to give direct care. Already the workload is very difficult for nurses to manage in the VA.

For example, in the outside sector we might find a nurse typically responsible for about five or six patients. In the VA that comes closer to 15 or 20. Then we add nonavailability of support services, and I think we are asking for more than they are able to provide.

We have had some experiences at the ward level, for example, with contracting-out services; for example, the window washers who come to our psychiatric wards. Though they are told that they are to close the windows and it appears in the work statement, the windows are left open. We almost routinely track them step by step so that the windows are not left open on our psychiatric units.

These kinds of safety factors are also of concern to nurses, because then it becomes their responsibility, at least it is a felt responsibility. For the safety of patients then, I as a nurse must make sure those windows are closed.

Mr. LEATH. That is a helpful statement, and I appreciate all of you taking the time to come to Washington to present your statement.

Thank you very much, ladies and gentlemen. We will submit to you some questions in writing that we would like for you to respond to for the hearing record, but in the interest of time we appreciate very much your coming here.[1]

Our next panel will be Mr. Albert Condino, the administrator of Our Lady of Victory Hospital in Lackawanna, N.Y., and Mr. Gary Mullennix, president, Huntington Laboratories, Inc., Huntington, Ind.

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[1] See p. 289.

Gentlemen, we appreciate your coming here today. We would appreciate if you would summarize your written statements. We will include them in full in the record.

STATEMENT OF ALBERT L. CONDINO, ADMINISTRATOR, OUR LADY OF VICTORY HOSPITAL, LACKAWANNA, N.Y.; AND GARY MULLENNIX, PRESIDENT, HUNTINGTON LABORATORIES, INC., HUNTINGTON, IND.

STATEMENT OF ALBERT L. CONDINO

Mr. CONDINO. Thank you, Mr. Chairman.

You have the written statement which I sent in advance of this hearing.

I would like to comment that in my experience in hospital administration with contract services I have been the person responsible for discontinuing contract services at three different hospitals, two with housekeeping services and one with a food service contract.

The reason we discontinued said services is that we found that they weren't performing up to standards, and we had the opportunity to do cost comparisons, and as such, in two specific instances I was involved in the discontinuance, and one I left the hospital prior to the final decision.

I am referring to departmental management, the organizational structure of the hospital. I am also referring to my experience both as an assistant administrator and as the chief executive officer, the administrator of the hospital.

I am also referring to my academic preparedness in hospital administration. I am not singling out or attempting to make a generalization that there is no room for contract service in any manner in hospital administration. I am referring again to the departmental management.

In departmental management, we do have contracts in some of the aspects of the hospital operation. However, I always like to think when I look at our hospital organization that when the employee gets paid the check says the name of the hospital, it doesn't say the name of the department. So we are working together as a team and, hopefully, a strong team.

I have found in my experience that the quality suffers with an outside contract service involvement in departmental management. I have also had the opportunity to do cost comparison studies, and their cost is not what they lead one to believe when they approach the hospital with their salesmanship as they attempt to enter into a contract with the hospital to run a particular department.

I am willing to answer any questions that members of this committee may wish to ask.

Thank you.

Mr. LEATH. Thank you, Mr. Condino.

[The prepared statement of Mr. Condino appears on p. 95.]

Mr. LEATH. We will let Mr. Mullennix make his statement, and then we will ask questions.

STATEMENT OF GARY MULLENNIX

Mr. MULLENNIX. I want to thank you for the opportunity of presenting this today, and the material that I have is there to be

submitted. What I want to do is not belabor the many points that have already been made by other witnesses this morning, because they have all been interesting, and very good.

There have been lots of sound responses, and all go to the quality of health care and the delivery of the health care.

Just to reiterate a number of those, the efficacy of care, the morale, the problems of determining the quality of the contractors at each of the 172 sites, the strikes that might arise and how those might be handled, the lack of fiscal flexibility, and a question that comes up continually, which I think an important is one, on accountability.

I know that contractually in a number of cases the contractor actually receives a 60-day period in which they can redress any grievances. That seems to me to be an awfully long time, and I am sure it is a concern for everyone.

But I really have three problem areas that I want to summarize and that I want to get in here.

One is risk. The risk of doing something like this, of turning over all of the employees to an outside contractor. No one likes to think of it, but what happens when something goes wrong? What is the Veterans' Administration's recourse? It is really extraordinarily limited, and it seems to me puts them in peril of having to accept virtually any terms the contractor might offer.

It isn't just the risk that the supervisors are pulled out. Rather, the fact that all employees, certainly in housekeeping, could be pulled out, and the hospital is at great peril.

The second is the myth of cost reduction, and I seriously mean that it is a myth.

There is a difference between cost reduction and cost savings.

If hospitals are overstaffed, I think they can be brought back into line. Generally speaking, the lure of cost reduction comes about as a major sales pitch, and I refer to one of the exhibits here—and I think the same thing is going to happen with governmental contracts—in which the contracts they will be let for bid.

In a situation at the University of Michigan that we are familiar with, in 1977 three different contractors were involved in a bidding process. As incredulous as it may sound, and it is in the exhibit I here, what was finally proposed virtually by all three after a long series of negotiations was a 40-percent reduction in staff.

To think that you could cut 40 percent of your housekeeping staff out and maintain the quality of health care is virtually impossible. I would just like to make one quote from that by Mr. Kenneth Bunn, who was the director of building services there. It says, and I quote:

> In regards to the number of custodians, I believe that all three companies are overly optimistic with a proposed cut of 40 percent. First of all, none of the companies have indicated any kind of a pool for absenteeism or open positions . . . it may not be needed for the phasing down of staff, but will we have a problem in one year? We just may. This area of Michigan is highly unionized and Ford, Chrysler and General Motors have not whipped this problem and they have been working on it for years.

And exhibit 2 goes on to prove or show that they did, in fact, have union problems.

The second item that I want to point out in exhibit 5 is that there really is no cost savings over what could be done. It is a very

complicated and extensive study from the Albert Einstein Hospital in which Mr. Peter Ryerson, a professional engineer, went through and took in-house versus American Management Services, Crothall and Servicemaster and showed that the in-house costs were some $100,000 lower than the costs from any of the outside contractors, and I would like to very quickly quote from him. He says:

> The in-house managerial concept would also reduce the current annual expenditures by approximately $100,000, and therefore would allow for a combination of cost containment, and increased emphasis in the overall cleanliness of the institution. Additionally, the in-house alternative allows for increased flexibility to provide other required services as the demands of the hospital change. These services specify areas to be cleaned, methods to be used, and costs associated, and any changes can require charges and possibly contract negotiations.

And I know that occurs from time to time.

Finally, in exhibit 7 we have—and we don't have access to all the hospitals, but we have a list of some—in excess of 100 hospitals that we know of who, since 1977, have canceled contract management services, and I think that probably they have some very good reasons for that and should be spoken with.

Thank you.

Mr. LEATH. Thank you very much, and Mr. Mullennix, we will include your complete statement in the record.[1]

I appreciate your comments, coming from the private sector. I think, at least what I am hearing is that you have tried a great many of these things that OMB is currently saying that are magic, and have found that they do not work quite so effectively in the private sector, and with this great efficient machine of Government that we have, I do not think we could expect it to work any better here.

Gentlemen, recognizing that Federal employees receive competitive salaries and competitive benefits, do you believe that the VA should be able to perform hospital housekeeping services as well and as cost effectively as a contract company can provide them?

Mr. CONDINO. I think they should be able to. The contract service is a profit-oriented operation, and I see no reason for VA, a Government agency, as similar to our not-for-profit voluntary hospital, not being able to provide competitive wages and benefits and operating effectively at a lesser cost than a profitmaking organization.

Mr. MULLENNIX. If I may respond to that.

The costs—and I know this sounds very simplistic, but it really is as simple as this—the costs of providing housekeeping services are made up primarily of the labor costs and the supervisory costs. Both of those account for probably 95 percent of the total cost. Five percent of the cost is left over for material, normally.

Now any hospital has to withstand those three—employees, supervision, and material.

What the hospital has to do under contract management is to withstand one additional cost and that is the cost of the contract itself, the fee charged by the for-profit organization that is in there providing this contract service. And the hospital should be able to save that. They should be able to do a better job.

Mr. LEATH. Mr. Condino, in the private sector is it customary for you to use housekeeping employees, for example, in an emergency

[1] See p. 96.

situation for whatever the need might be, or for that matter other employees of the facility if an emergency situation did arise?

Mr. CONDINO. Yes, it is, Mr. Chairman.

Mr. LEATH. We appreciate, gentlemen, very much your coming here this morning, and we appreciate the light that you shed upon this subject for us, and we thank you.

Our next panel will be Mr. Joseph Gleason, executive vice president of American Federation of Government Employees, Mr. Arte Pierce, president of the National VA Council of AFGE, and Ms. Virginia O'Dell, president of Local No. 2547 of AFGE, Iowa City, Iowa.

STATEMENTS OF JOSEPH D. GLEASON, EXECUTIVE VICE PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES; ARTE I. PIERCE, PRESIDENT, NATIONAL VA COUNCIL, AFGE; AND VIRGINIA O'DELL, PRESIDENT, LOCAL NO. 2547, AFGE, IOWA CITY, IOWA

STATEMENT OF JOSEPH D. GLEASON

Mr. GLEASON. It is good to see you again, Mr. Chairman.

Mr. LEATH. We are delighted to welcome all of you, and it is good to see you. We have not seen you since our mutual speaking engagement in Waco.

Mr. GLEASON. Since Waco.

Mr. LEATH. We are delighted to have you here. Joe, if you would care to lead off the panel and make any statement you would like we will include your complete written statement in the record.[1]

Mr. GLEASON. All right, Mr. Chairman.

Accompanying me this morning is Arte Pierce who is the president of AFGE's National Veterans' Administration Council, representing approximately 130,000 professional and nonprofessional employees in the Veterans' Administration. Also, Ms. Virginia O'Dell who is president of our local No. 2547 at the Medical Center in Iowa City, Iowa. And also with us is Monroe Johnson of our general counsel's office and Donald Haines from our legislative department.

I recognize, Mr. Chairman, that you have had a long and a full morning in terms of presentations, so I am going to try and keep, to the degree possible, my remarks very brief and to give you a synopsis of the rather extensive statement that we have submitted to the committee.

When I finish, Mr. Chairman, both Mr. Pierce and Ms. O'Dell will offer brief statements for the record,[2] and quite obviously would respond to any questions that the committee may have.

In our statement, Mr. Chairman, we deal specifically with the need for legislation in the area of contracting out. We speak further to what we believe to be the built-in bias of the current A-76 circular on the subject of contracting out.

Our statement deals with what we believe to be a false economy in terms of contracting-out, and we respectfully refer the committee to the examples illustrated on pages 5, 7, 11, and 13 of our statement relative to contracting-out experiences under A-76

[1] See p. 156.

[2] The prepared statement of Mr. Pierce appears on p. 174. The prepared statement of Ms. O'Dell appears on p. 178.

at various Federal facilities in the United States because of previous testimony given here this morning.

In the statement, Mr. Chairman, we speak to what we believe to be a potential shortchanging to both the taxpayers and the veteran recipients of service. We speak further to what we believe may be arbitrary and shabby treatment of career employees, and particularly career employees who are veterans of the armed services.

We further speak to what we believe to be a severe gap in terms of job requirements and statements of work by contractors. For example, poor and not realistic cost comparisons and deliberate underbidding.

We ask that the committee respectfully review page 6, the last paragraph, through page 8, the very first paragraph.

There were a number of comments offered this morning, Mr. Chairman, some of them facetious, but I am sure all with a very serious bottom-line intent, in the areas that have been suggested are up for review for contracting out, including the contracting out of the Chaplain Service.

I don't think there is perhaps any more sacred relationship other than that of the family unit itself, the matter of the family or the veteran with their chaplain or their minister or their priest as the case may be. I suggest, Mr. Chairman, that we become rather callous when we suggest that God can also become a rented or a leased service.

In our testimony, Mr. Chairman, we focused on the various ways in which OMB A-76 is biased, both in policy and in practice toward contracting out.

We have pointed out how A-76 does not even live up to its own minimal standards of fostering cost effectiveness. We would not, however, want to leave the committee with the impression that AFGE believes that cost effectiveness should govern contracting-out in the Veterans' Administration.

A single-minded focus on cost effectiveness, even if implemented fairly, would destroy other principles which are especially important in the Veterans' Administration. These principles, in our judgment, Mr. Chairman, now require legislative protection.

Very simply, Mr. Chairman, we don't come here to point out a lot of things that we necessarily feel are wrong or improper. We hope our presentation is one that can be considered both positive and constructive in terms of recommendations.

And we specifically—I respectfully suggest to this committee that it report out legislation that would do the following things, if you will bear with me:

One, prevent medical care and other benefits for veterans of the armed services from being sacrificed, either by direct budget cuts or through the guise of contracting out;

Two, prevent the contracting out of either direct or indirect patient care;

Three, prevent the effects of veterans' preference from being diluted through contracting out, and this was spoken to earlier by Congressman Edgar;

Four, preserve the control of Government managers over the entire VA work force, both in-house and contract;

Five, preserve the stability in the VA work force which Federal personnel now provide to this Government;

Six, insure that any contracting out permitted under the above standards also meets rigid cost-effectiveness requirements, including accurate and complete statements of work in the most efficient in-house organization and staffing; and

Seven, insure that the statutory requirements will be fully enforceable and not subject to bias in favor of contracting out.

There are two additional recommendations, Mr. Chairman, which do not appear in the prepared text. And they are:

One, it has been our belief and our position for lo some 15 years of testimony on the subject of contracting out, whether it was in VA or across Government generally, that there should be the creation of a central repository or depository for all contracts let by the Government, all agencies of Government, so that all of us would have a central source which we could go to find out indeed how much taxpayer money is being utilized on the subject of contracting out.

Mr. Chairman, the last recommendation is, and it is a recommendation that this union has made previously, the Veterans' Administration is the third largest employer in the country. It deals with a constituency running into the millions. It deals with people who have contributed in some cases much more than has been expected of the public generally.

Mr. Chairman, we think the time is long past, and hopefully this committee would consider a recommendation that the Veterans' Administration be made a Cabinet-level position.

You are aware, Mr. Chairman, of the rather unfortunate charade which occurred at the beginning of this year in terms of who was on first base and who was to be the Administrator of the Veterans' Administration. I would respectfully suggest if that were a Cabinet-level post we might not have gone through that exercise.

Although we are focused on the bias in OMB Circular A–76, no one should forget that the VA has already engaged in contracting out by using its own authority under title 38 of the United States Code. And as might be expected, many of the same problems arose—incomplete statements of work, greater cost, inadequate service and destruction of in-house capability have already occurred on a smaller scale.

My colleagues with me who work in the VA system will have more to say about that, but we urge that any legislation govern the VA's authority under title 38 as well as A–76.

If I may, Mr. Chairman, let me deal with a potentially sensitive area. I want to note that the VA's contracting out, potential contracting-out, places VA medical services at the risk of possible strikes by contract employees seeking better working conditions from the outside contractor. It is perfectly legal, as you know, Mr. Chairman, for contract employees to strike, and the fact that so many contractors are not organized increases the likelihood of strikes.

Many studies have shown that the most likely time for a strike is when employees first set up a union and negotiate their first contract under the National Labor Relations Act. Federal employ-

ees, as you know, are barred by law or by oath, take your choice, from striking.

More important than legal prohibitions is the dedication of the VA employee in doing their work, the dedication that now causes them to go to the hospital during blizzards and power outages just in case they are needed.

An increase in contracting out at VA would also raise the possibility of graft and corruption. The employer-manager relationship in a Government agency right now provides almost no opportunity for corruption. The large sums involved in letting contracts, however, and the intrusion of the profit motive present the opportunity for graft when contracting out gets underway.

It would sadden me to think that any of the scarce funds available for VA programs would be wasted through graft and corruption.

Mr. Chairman, for the record I would like to submit a copy of Resolution 119 adopted by the Thirteenth Constitutional Convention of the National AFL–CIO here in Washington in November in 1979.[1] That resolution was sponsored by our union at that convention and states in part:

Be it resolved, That the AFL–CIO supports the principle that public work which has been traditionally performed by public employees should continue to be performed by public employees.

This resolution, Mr. Chairman, continues to be the single AFL–CIO policy statement on contracting out. As applied to the Veterans' Administration and OMB the resolution clearly supports the efforts to insure that work that has been traditionally performed by VA employees should continue to be performed by those employees.

Now, Mr. Chairman, with your indulgence, I would turn to Council President Pierce for any comments that he may have.

STATEMENT OF ARTE I. PIERCE

Mr. PIERCE. Thank you, Mr. Gleason.

Mr. Chairman, my name is Arte Pierce, and as Mr. Gleason has indicated, I am president of the National VA Council of Locals, which governs the major portion of VA employees. Before I proceed any further, I might say to the chairman that I was asked to extend greetings to you from the officials of local 1822 at the medical center in Waco. So I have fulfilled that obligation and I will let them know at the first opportunity.

I have worked for the VA for 32 years and starting out as a messenger in charge of the responsibility of carrying letters and papers from one place to another. I now have the responsibility as a disability rating specialist and this means that I am involved daily with contact with the veterans as well as veterans' organizations in relationship to the various types of benefits that the VA offers.

The primary objective of the Veterans' Administration is service. And because of that objective we, as employees within the VA, have been able to establish on a day-to-day basis a common bond and that is to say that on many occasions there comes a time when we must perform a function which is not in our job description.

[1] See p. 174.

We perform that function because we know it is necessary in order to get the total job done. We are aware of that because of our day-to-day activities——

Mr. LEATH. Could I interrupt you, Mr. Pierce?

If you all will indulge me, since we are rather short on members, I need to run and vote and I will be back in about 10 minutes, and so if we could recess for about 10 minutes, with your indulgence, I would appreciate it.

The committee stands recessed for 10 to 15 minutes.

[Recess.]

Mr. LEATH. Thank you, ladies and gentlemen, for your indulgence. The committee will come to order and, Mr. Pierce, we will ask you to pick up where we interrupted you.

Mr. PIERCE. Thank you, sir.

As I was saying before we had the recess, within the VA, between the VA employees and our veteran patients, there is what we like to refer to as the common bond relationship which exists on a day-to-day basis, primarily because we as employees feel that we have responsibility which goes beyond any wording that might be in our job descriptions or anywhere else. We don't feel that there is any binding contract in a written form.

Often we are called on to respond and do things that are not in the job description, basically because we know they need to be done. It is for the welfare of our veterans that we do these things, and we know that there is no job description or performance standards or whatever that might be negotiated between the VA and the contractor that will cover this void.

To that extent we don't believe the contractors will be able to respond in this same fashion. The VA's own contracting experience demonstrates how scarce money is for medical care. Medical laboratory tests have been contracted out at various medical centers with the failure.

In Cincinnati, for example, the projected costs for contracting-out laboratory tests in fiscal year 1979 was $160,000. The Inspector General, that same service, even at a lesser fee basis could have been performed at a savings of $81,000, had it been done in-house. Following that inspection he ordered the VA to return to performing that function on an in-house basis.

We had an experience in the VA Medical Center in Denver, Colo., in 1979, where the VA contracted out to have a painting job done. The painters started, quit in the middle of the painting activity and left. We had to bring in our in-house painters to complete job, and the VA had already made an advance payment on that contract.

Much of our experience in the skilled trades area is representative of the employees who are unionized. We know that we have people onboard who can perform the function adequately fo all of our needs.

I am proud to say that in addition to being a VA employee for 32 years I am also a veteran of World W II. I served in the U.S. Army for 35 months, with 23 of those months being in the European theater of operations.

Personally as a veteran I am concerned about the possibility of being hospitalized in a VA hospital and wondering whether or not

some service that I might eventually need may be impaired because the contractor would not be able to respond in an emergency.

And all I am saying as a representative of our VA employees is to continue to let us do what we have been doing. We have done a good job, we will continue to do a good job, and we appreciate the concern that this committee has shown in the interests of our efforts and the welfare of our veterans, and I promise you our cooperation for the success.

Thank you very much.

Mr. LEATH. Thank you, Mr. Pierce, for an outstanding and heartfelt statement. We appreciate it.

Ms. O'Dell.

STATEMENT OF VIRGINIA O'DELL

Ms. O'DELL. My name is Virginia O'Dell, and I am president of AFGE Local No. 2547 at the VA Medical Center in Iowa City, Iowa.

I have been a nurse for 17 years, the last 6 of them in the VA.

I work in hospital based home care, which is one of the special health care programs of the VA. By treating patients in their homes we eliminate unnecessary trips to the clinics and shorten hospital stays. This helps VA save money which it then uses on other medical care.

Most of the VA employees in Iowa City are veterans, and they include disabled veterans and several former POW's. They are proud of their jobs as the veterans caring for veterans program.

The single most important message I want to give this committee is that we don't have to wait for contracting-out to hurt the VA. A-76 and contracting-out has already harmed the VA hospital system.

I cannot tell you how often I am asked by other VA employees whether they will have a job next year. They ask, "Should I sell my home because I won't be able to make the payments if my job is contracted out." Others have saved money and are thinking of buying a house. They ask if they should buy one.

Frankly, it angers us out in the field because we know how important our work is. We have the feeling that someone in OMB decided we were going to be contracted out, regardless of what it costs either in money to the VA or in care to the veteran.

Many of the VA patients have read about OMB's plan for contracting out in VA hospitals in their veterans service publications. The patients waver from being fearful to being furious.

I am proud to say that I work in a VA hospital. From the first day on the job VA employees learn that our job is to serve the veteran. Our rule is the patient comes first. And since many of the employees are also veterans they know that they may be in the hospital one day. So they take extra care to see that they do indeed serve the veteran.

Frankly, it is not the same with the contract employees we already have working in Iowa City.

We contracted out maintenance to our boiler plant and our chiller plant. Last spring the chiller plant could not seem to get the air-conditioning in the operating rooms right, and I was told that the contractor had put in the wrong refrigeration pipes and our in-house workers had to fix it.

In 1979 the contractor's employees for the boiler plant caused a fire by welding in an area filled with coal dust. The fire spread through the mail chutes and the fire trucks could not get to the fire because the contractor's vehicles blocked the fire lanes. Ten VA employees wound up in the medical intensive care unit with severe smoke inhalation because they fought the fire.

As a nurse I want to stress how important to patient care are the activities of a lot of workers whose jobs are targeted for contracting-out.

We had contract carpenters who worked in a surgery ward but didn't bother to put up dust barriers. You could see clouds of plaster dust in the air as you walked down the hall. They carted off the old plaster in open wheelbarrows, and patients, nurses, visitors, and volunteers had to walk through their spillage.

Patients on that ward all had new surgery wounds and many developed staph infections because of the dirt. In fact, surgery was suspended in the ward for awhile.

I am not saying the contractor's employees did this on purpose. They were hired by the contractor to tear out a wall. But where was their concern for the VA patient? VA employees rarely are so shortsighted. The veteran comes first.

Our janitors are an important part of the health care team. When the janitors attend to all their duties, cleaning the rooms and furnishings, wiping up unexpected spills and others, the nurse is available to provide patient care. If a contractor tries to make money by relying on a transient, minimum-wage work force I can guarantee the nurse will end up swinging mops instead of nursing patients.

As a nurse I know the groundskeepers contribute directly to patient care.

At Iowa City we have 3 groundskeepers and about 20 patients who help them either in a voluntary or minimum-wage capacity. Their work outside, whether planting flowers or trimming hedges, has a therapeutic value for these patients that you couldn't possibly measure in an OMB circular. Because the groundskeepers are veterans they make sure that the patients' work is as beneficial as possible.

Can an outside contractor whose goal is a higher profit be relied on to do the same? Of course not.

As a nurse, though, I want you to know that you can see the difference in these patients when they are able to put in their work on the grounds.

Finally, I want to leave this committee with two thoughts. As a nurse I wonder who will be in the kitchen fixing the special diets or in the laundry cleaning the linen when the contract employees go on strike? Our contract employees in Iowa City have already engaged in strikes. Fortunately, we had enough VA employees who cared enough to spend extra hours getting the contractor's job done.

VA employees have neve gone on strike, not even when we didn't get our paychecks last year because the appropriations bill hadn't been passed.

My last thought is really a special plea. Congress has to do something so that VA employees, all Federal employees really, stop

falling behind everyone else in pay. We got a 4.8-percent increase this year. Right across the street the University of Iowa Hospital employees got 8 percent. I don't believe their standard of care exceeds ours.

For comparison, the municipal fire department got a 14.2-percent increase.

VA employees deserve a fair wage just like everyone else. They do not deserve the stress and turmoil of wondering whether they are going to lose their jobs because someone behind a desk at OMB in Washington, who I don't believe is a veteran, decided that VA hospitals no longer need VA employees. We wonder if OMB's next decision will be that veterans no longer need VA hospitals.

I thank the committee and would be pleased to answer any questions.

Mr. LEATH. Ms. O'Dell, I want to thank you for a truly outstanding statement.

You mentioned that you had had experience with contract employees that had in fact gone on strike. Could you elaborate on that?

Ms. O'DELL. That is correct.

Mr. LEATH. What function were they performing?

Ms. O'DELL. They were carpenters working for a contract employer.

Mr. LEATH. I want to thank all of you for excellent statements, which I think will be very meaningful in this record as the committee and the entire Congress considers this problem. Mr. Gleason, let me ask you a question that OMB seems to always dodge when we talk about the fact of contract employees and their union relationships.

What would be the situation if you had a function contracted out, say it be housekeeping, for example, or food service, or whatever, and those contract employees did in fact strike, for whatever the reason might be, and form picket lines outside the facility. What would be the position of the AFGE as far as your employees are concerned in that very delicate situation?

Mr. GLEASON. Mr. Chairman, philosophically, obviously it would be extraordinarily difficult for us as an affiliate of the AFL-CIO.

However, by recognizing, obviously, the right of employees in the private sector under the National Labor Relations Act to exercise all of the rights and privileges that they have, however we are cognizant of the way the law is currently structured and the Federal employees, and Ms. O'Dell spoke to her own situation at that particular installation, cognizant of the prohibition on striking based on the oath that a Federal employee takes, we would probably have, and again philosophically, have difficulty with this, Mr. Chairman. But being a very practical person our people would have to cross such a picket line to go in to work at the facility and obey the law that is currently on the books.

Mr. LEATH. There is no question, though, that if this happened to a great degree across the country it would create a great deal of emotional strain and tension that would tend to be very disruptive, not only to your employees but to the patients.

Mr. GLEASON. Yes, indeed, it would, Mr. Chairman.

One additional thought, too, is that groups of people who exercise their rights at some time can become highly emotional, those who have the responsibility that Federal employees do may feel a sense of threat to their physical well-being, and I would say to you, Mr. Chairman, that we have given instructions to local unions whether they were in the Veterans' Administration or other agencies of Government if there is any reason for you to feel that there is a threat upon your physical well-being, do not cross that picket line. Let us know and let us take it up with the agency of Government involved.

So I just want to add that addendum, if I might, to the earlier statement that I made. While we would do what we are required to do under law, not at the threat of bodily harm to any of our members or to the Federal employee.

Mr. LEATH. I think that you are saying is totally responsible. What you are saying I think is totally realistic. I believe the same way, that regardless of what position you might take as a union, that none of us can control individual situations, and that the potential for disrupting situations occurring would be very strong.

Mr. GLEASON. It would be much greater, Mr. Chairman, if I might respectfully interrupt you. We are talking about the potentiality of somewhere in the neighborhood of 30,000 to 35,000 people who could conceivably lose their job to private contracting.

It is that element of employees in the Veterans' Administration or any other agency of Government that, as we look at potential contract-outs, that would be most prone to private sector unionism, most prone to utilize all of the facilities that they have under the National Labor Relations Act, and OMB and a number of other people want to look at this very, very seriously. It just can't be dismissed by the simple waving of a hand and saying you can't strike or you shouldn't strike. Because indeed, as we both know, Mr. Chairman, those are not the realities of the real world.

Mr. LEATH. I would like for any of you to respond to this if you have a comment to make on it—this administration had not been in town very long, and they came forth with the proposition that they were going to close all the VA regional offices and consolidate them, and came forth with the proposition that they were going to consolidate health care. I have not figured out exactly how you do that.

After this committee, and, of course, our counterpart in the Senate, vigorously opposed those efforts, fortunately they were turned around. Now we are faced with this accelerated push for A–76.

I have spent a great deal of time in the VA facilities I have in my district, because I am concerned about the care for the veterans and I am concerned about those employees who are charged with the responsibility of giving that care because we cannot have one without the other. What is the morale in the VA generally? I am not talking about just among groundskeepers or maintenance personnel, I mean the whole system.

In my judgment we have a severe morale problem throughout the whole system, because there is a tremendous degree of uncertainty at this point among the employees, regardless of whether

they are nurses or case supervisors or whatever they might be. Could you give me some of your first-hand responses to that?

Mr. GLEASON. Mr. Chairman, I think this is a question that both Mr. Pierce and Ms. O'Dell, being closest to the scene, can probably answer with a great deal more articulation than I can.

However, for the reasons enunciated in Ms. O'Dell's statement the concern among the Federal employees, be they in the VA or other agencies of Government, is not with the sole issue of contracting-out, that is one of a multiple amount of concerns that they have, whether it is a potential merger of their retirement system with Social Security, whether it is the elimination of a cost-of-living adjustment, whether it is a failure of the Government generally to conform with the provision of the Pay Comparability Act of 1970—a whole laundry list of concerns that probably, now this is a professional observer's judgment, I would say that of the 18 years that I have been with the American Federation of Government Employees the morale in the Federal sector in the VA has probably, if you put it on a scale of 1 to 10 is minus 5.

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Mr. PIERCE. I support that wholeheartedly. As I said, I have worked for the VA, and all of my Federal experience has been with the VA, so I have got 32 years of looking at the VA from its position in 1949 up until today, and I have never seen the morale at a lower level.

As the chairman indicated, the early part of the year we were going through throes of wondering whether or not we were going to have a job, the reduction in force as a thing hanging over our head, the consolidation of regional offices, the closing of hospitals and all of those things in that area. We finally got away from that through the action of the Congress only to be told we are going to get you another way, we are going to do that through contracting-out.

And I might say that not only the VA employees but our veterans around this country are aware of the potential destruction of the VA, and I use that term because as a veteran that is the way I feel about it. If we contract out VA we destroy VA; and I don't want to see that. And neither do the 20 million or more veterans around this country want to see that.

And the veterans in this country and the employees in the VA are looking to us to express their feelings about it and they are looking to this committee as an arm of the Congress to maintain the VA in its present status.

Mr. LEATH. Mr. Pierce, you have indeed expressed that very well.

Ms. O'Dell, would you care to——

Ms. O'DELL. I agree with both Joe and Mr. Pierce, and I would like to add not only is the morale very low in the VA at the present time, the uncertainty of the future and the fact that personnel ceilings have been cut, therefore, the personnel within each agency are doing more work and they feel like they are not being thanked for it, and they are tired of being the example of the American workers.

Mr. GLEASON. May I, Mr. Chairman, just offer one last thought, that it would certainly be appreciated if this committee might possibly direct its attention to—and we are going to make this representation before other members of the other committees of

Congress—somewhere we have got to get away from this concept that public employees are public enemies, and that is an unfortunate thing, Mr. Chairman.

As you know, many people running for office in the Congress and in the executive branch, they have talked about getting the so-called Federal bureaucracy off the backs of the people. I would suggest, respectfully, Mr. Chairman, that maybe we ought to look at the ratio of managers to employees in the Federal Government. Maybe, indeed, that kind of bureaucracy needs to be looked at.

But as a general concept we get exceedingly tired of seeing the career Federal employee being attacked as a public enemy.

Thank you.

Mr. LEATH. I think that is a point well taken, and I have to admit that I think all of us who are Members of Congress in particular tend to fall victim to that. And it is unfortunate. There are, as there are in this body, Federal employees who I am sure could be characterized in that manner, but certainly I would agree with you that that is the exception rather than the rule.

Again, I want to thank each of you and the other witnesses that we have had this morning.

Do you want to——

Mr. HAINES. Mr. Leath, if I could mention one thing.

My name is Donald Haines. I work in the legislative department of the national office of AFGE.

First of all, let me personally commend you for the work you did in the compensation bill. It obviously took a great deal of effort, with the number of players, but we know the key role that you played and we certainly communicated that to our people. We are extremely grateful.

The breather that is provided by the provisions in section 601 of that bill will allow us to address the situation without already having contracting-out occurring.

We want to stress, however, that a lot of contracting-out is already going on. That some of that occurs without even the minimal safeguards that A-76 provided.

I was struck by the OMB testimony this morning when there were several suggestions that really OMB develops its circular to the input of interested parties, that unions have played some role in that.

Monroe Johnson is from our office of general counsel and before we came up I asked him if he could explore exactly what was our input, did we attempt to mold OMB Circular A–76? Did we identify problems, and if so, how did OMB respond? And he has a little research that I think the committee would find interesting.

Mr. Johnson, could you just read in your findings?

Mr. JOHNSON. Thank you, Mr. Chairman.

AFGE submitted 24 pages of comments on July 14 and again 23 pages on November 22, 1977, on proposed changes, and further submitted on August 21, 1978, a 24-page comments and recommendations on proposed revisions of OMB's Circular A–76.

Five major points proposed by OMB were that:

One, the Government should not compete with its citizens and that the Government's business is not to be in business.

Two, A-76 would not justify conversions to contract solely to meet personnel ceilings.

Three, activities below $100,000 in annual operating costs would be converted to contract without a cost analysis.

Four, the Federal employee retirement benefit cost factor would be increased to 20.4 percent, and

Five, determinations of appeals would be made by an official at the same or higher level than the original approving official.

To these AFGE responded that:

One, Government does not compete with its citizens. We believe that the business of private industry should not be Government.

Two, the use of the word "solely" allows agencies to contract out to avoid personnel ceilings, as long as they identify any additional rationale, however inadequate.

Three, conversion to contract without a cost analysis is wrong for operations under $50,000 and even more so for operations up to $100,000.

Four, the retirement benefit cost factor of 20.4 percent offers an incentive to prospective contractors to establish an inadequate retirement system for their employees, and the Government ultimately pays the cost with problems in social security and welfare after these people retire.

Five, appeals should be subject to a truly independent and objective review outside of the normal chain of command.

Mr. Chairman, the response by OMB to these points was to publish the revised A-76, with the exact language to which AFGE had objected.

Thank you.

Mr. LEATH. Thank you very much, Mr. Johnson. We appreciate having that in the record and if you will submit the full text of it we would be happy to include it.

Again I want to thank you. I wish we could have had a larger number of members here throughout the session but, as you all know, when hearings go for the length of time we have today, they also have other commitments.

Of course, I cannot speak for the committee but I think I know the sentiments of this committee very well and can say that I think we have learned a great deal here today. We have seen OMB, as far as I am concerned, in a very feeble manner, attempt to defend their actions with A-76. We have seen a great many people who are down at the delivery level where it really counts, as some old sage said, where the rubber meets the road, who have said, look, if we push this thing too far it will not work.

I am very much convinced of that. I have taken a tremendously active role in this thing during the time that I have been in Congress. As most of you know, we have had some language included in the defense authorization bill that was designed to bring a halt to this mandated push from above that says you will contract out *x* number of jobs, and then they allocated here, here, here, and here. And we all know what happens in a situation like that, a management team is going to be forced to use whatever figures it can cajole in order to make it come up so that they can meet their quota.

I think that is irresponsible and it displeases me a great deal that committees like Armed Services, and committees like this one, have to spend our time trying to continually put up stopgap blocks to keep a rather insensitive agency from just storming over the rights of our citizens.

I think Ms. O'Dell summed it up quite beautifully when she said that somebody in OMB has decided that regardless of what the cost is or regardless of what it does to health care that they are going to implement these things.

Unfortunately, I think history shows us that this agency, throughout most of its life, has held this view and that this is a battle that we can say is never going to be completely won until there are some retirements and changes in that greatest of all bureaucracies, which is OMB. And certainly I would hope that some of the messages that this committee, and this Congress, has sent over there, including the complete denunciation of the initiatives that we talked about earlier as far as consolidation of the regional offices and consolidation of the hospitals, and also language on legislation that I was proud to introduce which sets a minimum bed level in the VA health care system, which I think is something that had to be done in order to keep this erosion from continuing, and the little provision that requires stronger congressional oversight and resubmittal by the Veterans' Administration of any facility that affects 10 percent or more in any one year, up to 15 percent of the employees of any installation in the VA within a 2-year period.

And, of course, I was delighted when Chairman Montgomery was able to work out with the Senate the prohibition against spending funds out of the medical care account, millions of dollars, to study whether or not we are going to do this or not.

I would hope that the record that has been established by this hearing, which I think is a very substantive record, a very realistic record, would be taken into consideration by those at OMB who seem to be bent on doing away with the VA health care system in this country. They are not going to do it.

And I do not know how much more emphatic this Congress can get than it already has on the several occasions that we have tried to send that message over there.

So I would thank all of our witnesses this morning. I think it has been one of the finest hearings that I have attended in the 3 years that I have been in Congress, and, hopefully, it will give us the ability to get a handle on this thing and put it to rest once and for all.

I do not think there has been anybody testifying here this morning who is not willing to have the Government save money when it is to the best interests of the taxpayers and the best interests of the people the Government serves, but there is nobody in this body that is any more conservative in his political views or his fiscal views than this Member, but there are times when things become totally counterproductive.

There are times when things are dreamed up by people who can make it look good on paper and use figures to make any kind of an argument that they want to make, but it simply does not fit the situation.

And I am convinced that that is exactly the kind of thing that we have with A-76 throughout this Government.

So, having said that, the committee will stand adjourned.

[Whereupon, at 12:53 p.m., the committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF HON. TOM HARKIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Thank you for allowing me to present testimony on the issue of contracting out at Veterans Administration hospitals. I am honored to do so.

The Reagan Administration claims that the government's "longstanding policy of not competing for business with citizens," compels it to require VA hospitals to dismiss some experienced workers and advertise for outside contractors to provide the same services.

Every one of us here is in favor of cutting government spending, and no one would deny that there are some instances where services can be supplied in a cheaper and more efficient manner by contracting out. But I am concerned that the decision to begin across-the-board contracting out within the Veterans Administration may create more problems than it solves.

One thing that I find particularly troubling is that no one familiar with the functioning of individual VA hospitals was consulted about this change and its effect on the quality of health care our veterans deserve. The instructions to contract out all emanate from OMB Circular A-76, which specifies "Policies for Acquiring Commercial or Industrial Products and Services Needed by the Government." In fact, many of the administrators and employees that I have been in contact with think contracting out will lead to higher costs, a deterioration of services and poorer management since control is divided between hospital administrators and contractors.

Let me elaborate. A case can be made that contracting out will make it more difficult for VA hospitals to provide quality medical care to our nation's veterans. It will be more difficult because dietary services, plant maintenance and engineering functions are essential to the total operation of a medical center. If these services are contracted out, the total operation becomes disjointed and the quality of care our veterans receive will inevitably deteriorate.

The services provided by VA hospital workers cannot be compared to serving food in a restaurant or cleaning ashtrays in an office building. VA hospital workers care for sick patients who have special needs. Yet, instead of a meal prepared by dieticians at the hospital, our veterans can expect a frozen dinner heated in a microwave. That's not quality medical care, in my opinion.

I am also concerned that the criteria used to determine whether to contract out completely neglect considerations of the unique circumstances of individual hospitals. VA hospitals differ in the type of services they provide, the typical length of patient care (short- or long-term) and other aspects. Doesn't it make more sense to adopt a flexible, case by case approach to contracting out and decide each case on its merit?

This plan will impose tremendous economic hardships on our local communities and small businesses there. When construction projects use federal money, we require environmental impact statements to assess the effect on the local community. These statements include an economic impact section to detail the effects of the project on local socio-economic conditions, community cohesion and the impact on the local government's financial situation. I think it's also necessary to acknowledge these factors before contracting out.

For example, Knoxville, Iowa, has a population of about 8,000. The VA hospital is the major employer there and 316 jobs are now on the line. Since the government adheres to guidelines regarding veteran's preference, many of the workers are veterans. Of the 91 workers employed in building management, 60 are veterans. In engineering, 67 of the 93 workers are veterans. That's almost 70 percent in those two divisions. Thus, by contracting out, the government is indirectly reducing its mandated obligation to give employment preference to veterans.

Some of these workers may be able to continue in their present jobs as employees of the contractor. But they would probably have to accept lower wages and benefits and lose seniority. I have to agree with the Knoxville resident who said "Contract-

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ing out is an attempt to save money by cutting wages. There are other ways to save money. I can't see doing it by reducing the living standards of the people."

Most of the people who work in the dietary, engineering and plant maintenance departments have given years of dedicated service to improving patient care. And while their dedication and expertise have not yet been lost, their spirit has been crushed. These people may very well have their livelihood contracted out. This would have a devastating effect on the community. The government would, in effect, be perpetuating the type of crime many private corporations have been accused of: Pulling out and leaving workers stranded without jobs or accrued benefits.

Proponents say contracting out will save taxpayer's money. But that's just a guess because this hasn't been tested. I question the long-term cost savings that might be projected from "foot-in-the-door" first-year bids. Contractors can increase their prices dramatically in subsequent years, after the in-house capability has been destroyed. Our distinguished colleague Congresswoman Patricia Schroeder made a good point in her statement to this committee last July 14. As she said, "The contractor has the government over a barrel in renegotiation and uses this superior position to extract profits." For example, the cost of a contract for custodial services at a medical center in Denver rose 25 percent between the first and second years. This was three to four times the rate of inflation for that period. Without a test program, there is no justification for saying that contracting out will save money.

Proponents also suggest that contracting out will help small businesses. But I fail to see how bringing in frozen food from Chicago helps small grocery stores, butchers and appliance dealers in Knoxville. VA hospitals across the country must all advertise at the same time, so contractors can bid for regional contracts. I doubt that companies with the capacity to serve regional areas can be considered small businesses.

I think it's vitally important for VA hospitals to provide quality medical care. The services OMB wants to turn over th private contractors are essential to achieving that goal. Contracting out simply puts additional indirect employees on the federal payroll and then removes them from managerial control. It shifts responsibility for the operations of the VA hospitals away from hospital administrators to private firms. This diminishes the accountability of federal officials to the public they are paid to serve.

This proposal will result in higher costs to the government, a decline in services to our veterans, and disregards any impact on the local community. It's ridiculous to launch a nationwide program without testing to see the effects in these areas. I urge that such a test be undertaken. In the meantime, I would like to see this committee consider legislation to require VA hospitals to draw up an economic impact statement describing the impact on the community before any contract is let. This information will give those people in decision-making positions a more accurate assessment of the total costs of contracting out.

Mr. Chairman, I would like to thank you for holding this hearing today. I congratulate the members of this committee for taking a thorough look at the effects of OMB Circular A-76 on the services at VA hospitals.

STATEMENT OF DONALD E. SOWLE, ADMINISTRATOR, OFFICE OF FEDERAL PROCUREMENT POLICY, OFFICE OF MANAGEMENT AND BUDGET

Mr. Chairman and members of the committee, thank you for inviting me here today. The Office of Management and Budget (OMB) appreciates the opportunity to continue the dialogue begun with the committee on July 14, 1981.

There are several issues I would like to center my discussions on today. These are:

Proven contracting techniques the Veterans Administration (VA) can use to ensure qualified contractors are selected to perform support type hospital services; the application of the circular to the VA's mission of providing direct medical care to qualified veterans; and the private sector's use of contract services in the health care field.

With respect to the first issue, let me state that the proper use of proven contracting techniques will assure that responsive contracts are entered into and that the Government is satisfied with the service or product acquired. There are three critical phases in the contracting process which ensure either success or failure in obtaining products or services needed by the Government. These are:

Developing a statement of work (SOW); selecting a qualified contractor; and evaluating contractor performance.

Let us briefly examine each one of these elements.

The SOW is one of the most critical elements in the process and is recognized as such. Our current policy provides that the work statement should clearly state what is to be done and provide performance standards for each task in the SOW. It is

these two elements * * * clearly stated requirements and performance standards * * * that establish the necessary ingredients of communication of the Government's requirements and provide the criteria that can be used to select a qualified contractor. It also becomes the basis upon which government inspection is made to ensure satisfactory contractor performance.

Last year OFPP published a pamphlet on writing and administering performance statements of work for service contracts. This document was based on extensive field experience and, incidently, was thoroughly tested in hospital services prior to its original publication by the Department of the Air Force and subsequently adopted by OFPP as a method that should be used Government-wide. I am happy to report that the Department of Medicine and Surgery in the VA has adopted this highly successful approach for work statement preparation for many of their requirements.

Another critical aspect in the contracting process is the selection of a qualified contractor. There are several techniques available including the performance of technical evaluations and preaward surveys to ensure a qualified and responsible contractor is selected. Every contracting officer has the right and, indeed, the obligation to make a positive determination that a bidder can satisfactorily perform the requirement prior to award of a contract. If management and technical requirements are critical factors, the contracting officer along with the Requirements Office can evaluate and examine the contractor's proposal in such areas as management and staffing plans; approaches to quality control; ability to provide an orderly phase-in; understanding of technical factors associated with the service; strike contingency plans; and, in the hospital environment, the contractor's ability to meet the standards of the Joint Committee on Accreditation of Hospitals.

The third and final critical point in this process is a determination of whether the contractor is satisfactorily performing the contract. Over the past few months, concern has been expressed that contractor services may be unsatisfactory because of shoddy workmanship. Again, I would like to point out that a sound statement of work with written performance standards and the selection of qualified contractors will essentially preclude poor performance. When one adds to this the quality assurance techniques required of the contractor, I can assure you that there is no reason to expect less than satisfactory performance. Further, ample remedies exist in the procurement process, ranging from monetary deductions to defaulting the contractor, to make sure that the Government receives what it contracted for and that we only pay for what we receive.

The second issue I would like to briefly address and one which is of concern to you, is the application of the circular to VA's mission of performing direct medical care. As you are all aware, the revised circular was published in March 1979 and applies to all Federal agencies including the Veterans Administration. There are several agencies, in addition to VA who, as a part of their mission, provide health services. The application of the circular to those activities listed in attachment A is a determination made by each agency head. In implementing the circular, agency heads examine such areas as existing statutes and individual functions to assure they are not inherently governmental or otherwise precluded from being contracted. In the case of VA their General Counsel in an opinion, dated March 21, 1980, concluded that contracting out direct patient care is precluded by law under title 38 and Public Law 79-293 and, therefore, must be performed by Government personnel. However, they also concluded that support activities not directly related to patient care are subject to the provisions of the circular. I would like to state that OMB supports this position.

The final area I wish to address is the private sector's use of contract services in the health care arena. In the July 1981 periodical entitled "Modern Healthcare" you will find a rather enlightening article on this subject entitled "Contract Management Survey." The highlights of this article are:

Some 4,079 hospital and health care facility departments were managed by outside contractors in 1980;

Cost containment pressures are the primary factors for the use of contract services in clinical and nonclinical areas;

The services most frequently contracted for are: Housekeeping, food service, respiratory therapy, plant operations maintenance, pharmacy, laundry and other services; and finally;

Contracting out support services "Allows a hospital to concentrate its energies on its main purpose—healing the sick."

We support the judicious and proper application of the circular in the VA hospitals where such application would not adversely affect the excellent health care services currently offered by the VA.

We in OMB are very much concerned with the loss of management flexibility as a result of the language contained in section 601 of the "Veterans' Disability Compensation, Housing and Memorial Benefits Amendments of 1981" bill. As indicated by the President when he signed the bill we will work with you to allay your concerns and find a mutually agreeable approach to the application of the circular's provisions to the VA.

I will be please to answer any questions you may have at this time.

Thank you.

ATTACHMENT I

Activity Number	Activity Description	Austin Capital Investment	Austin Annual Cost	Austin FTE	Hines Capital Investment	Hines Annual Cost	Hines FTE	Los Angeles Capital Investment	Los Angeles Annual Cost	Los Angeles FTE	Philadelphia Capital Investment	Philadelphia Annual Cost	Philadelphia FTE	St Paul Capital Investment	St Paul Annual Cost	St Paul FTE	Satellite - Center Capital Investment	Satellite - Center Annual Cost	Satellite - Center FTE
201	Analysis	28	1,071	34	25	2,610	64	37	408	10	8	195	7	45	125	4		-	-
202	Keypunching	49	71	4	64	159	13	9	24	1	33	131	7	-	-	-	27	42	3
203	Programming	134	6,334	196	30	2,100	80	34	272	9	34'	744'	25'	68	335	15	-	134	4
204	Data Entry	156	791	38	469	192	10	37	25	1	124	267	16	201	439	24	41	42	3
205	Processing	10,514	4,759	114	23,694	2,398	88	8,446	2,240	61	10,713	2,508	74	2,280	1,973	69	4	155	8
205	Processing (Clin Lab)	-	-	-	-	-	-	-	296	14	254	158	6	-	-	-	-	-	-
206	Installation & Maintenance	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	319	115	2
207	Operations & Maintenance	-	-	-	6,500	987	29	-	-	-	-	-	-	-	-	-	-	205	10
421	Microfilming	423	349	8	182	65	3	-	-	-	-	-	-	94	40	3	-	-	-
433	Printing & Reproduction	15	107	3	29	126	2	-	-	-	-	-	-	-	-		-	-	-
434	Word Processing	-	-	-	-	142	3	-	-	-	-	-	-	-	-		-	-	-
437	Training	-	-	-	68	11	.5	-	-	-	-	-	-	-	-		-	-	-
438	Motor Vehicle Transportation	-	-	-	-	64	3.2	-	-	-	-	-	-	-	-		-	-	-
439	Transportation-Cashiers Fund	-	18	1	-	-	-	-	-	-	-	-	-	-	-		-	-	-
602	Automated Mail Inserting	-	-	-	114	209	9.5	-	-	-	-	-	-	-	-		-	-	-

Does not include $46,000 annual operating costs and 2 FTE for programming support of Clin Lab

ote - Capital investment and Annual (operating) cost figures are in thousands (000's)

Veterans' Administration, Schedule of Cost Reviews; Department of Veterans Benefits

Agency: Veterans Administration.
Action: Notice.
Summary: Under OMB Circular A-76, Policies for Acquiring Commercial or Industrial Products and Services Needed by the Government, the Veterans Administration will be conducting cost comparison reviews at various field stations within the Department of Veterans Benefits to determine the feasibility of contracting out specific tasks to private contractors. The following list of stations, functional areas of review, and schedule of review dates is published for the notification of all interested parties.
For further information contact: Robert A. Jones, Chief, Records Management and Supply Liaison Division, Department of Veterans Benefits (232B), VA Central Office, 810 Vermont Avenue NW, Washington, DC 20420, (202) 389-2972.
Dated: August 7, 1981.

Robert P. Nimmo,
Administrator.

Functional Area: Centralized transcription activities

Field station	Date of review
Albuquerque, N. Mex	Dec. 15, 1981.
Atlanta, Ga	May 31, 1982.
Baltimore, Md	Mar. 1, 1982.
Bose, Idaho	May 31, 1982.
Boston, Mass	Aug. 31, 1982.
Buffalo, N.Y	May 31, 1982.
Chicago, Ill	Mar. 1, 1982.
Cleveland, Ohio	May 31, 1982.
Columbia, S.C	Do.
Denver, Colo	Mar. 1, 1982.
Des Moines, Iowa	Do.
Detroit, Mich	Aug. 31, 1982.
Ft. Harrison, Mont	Do.
Hartford, Conn	Mar. 1, 1982.
Honolulu, Hawaii	May 31, 1982.
Houston, Tex	Dec. 15, 1981
Huntington, W. Va	May 31, 1982.
Indianapolis, Ind	Mar. 1, 1982.
Jackson, Miss	May 31, 1982.
Lincoln, Nebr	Aug. 31, 1982.
Little Rock, Ark	Do.
Los Angeles, Calif	Mar. 1, 1982.
Louisville, Ky	May 31, 1982
Manchester, N.H	Dec. 15, 1981.
Milwaukee, Wis	Aug. 31, 1982.
Montgomery, Ala	Mar. 1, 1982.
Muskogee, Okla	May 31, 1982.
Nashville, Tenn	Mar. 1, 1982.
Newark, N.J	Do.
New Orleans, La	Do.
New York, N.Y	Do.
Philadelphia, Pa	Aug. 31, 1982.
Phoenix, Ariz	May 31, 1982.
Pittsburgh, Pa	Mar. 1, 1982.
Portland, Oreg	Do.
Providence, R.I	Aug. 31, 1982.
Reno, Nev	Dec. 15, 1981.
Roanoke, Va	Mar. 1, 1982.
Salt Lake City, Utah	Aug. 31, 1982.
San Diego, Calif	May 31, 1982.
San Francisco, Calif	Aug. 31, 1982.
San Juan, P.R	Do.
Seattle, Wash	Dec. 15, 1981.
Sioux Falls, S. Dak	May 31, 1982.
St. Louis, Mo	Aug. 31, 1982.
St. Paul, Minn	May 31, 1982.

Functional Area: Centralized transcription activities—Continued

Field station	Date of review
St. Petersburg, Fla	May 31, 1982.
Togus, Maine	Dec. 15, 1981.
Waco, Tex	May 31, 1982.
Washington, D.C	Aug. 31, 1982.
Wichita, Kans	May 31, 1982.
Winston-Salem, N.C	Mar. 1, 1982.

Functional Area: Automated mail inserting

Field station	Date of review
Los Angeles, Calif	Dec. 15, 1981.
Milwaukee, Wis	May 31, 1982.
Philadelphia, Pa	Dec. 15, 1981.
St. Paul, Minn	Do.

Functional Area: Keypunch

Field station	Date of review
Cleveland, Ohio	Dec. 15, 1981.
Milwaukee, Wis	Do.
Montgomery, Ala	Do.
Nashville, Tenn	Do.
New Orleans, La	Do.
New York, N.Y	Do.
San Juan, P.R	Do.
St. Petersburg, Fla	Do.
White River Junction, Vt	Do.

Functional Area: Microfilming

Field station	Date of review
Cleveland, Ohio	Mar. 1, 1982.
Milwaukee, Wis	Do.
Philadelphia, Pa	Do.
St. Paul, Minn	Do.

REVISED SCHEDULE OF COST REVIEWS; DEPARTMENT OF VETERANS BENEFITS

Agency: Veterans Administration.

Action: Notice

Summary: In accordance with OMB Circular A-76, Policies for Acquiring Commercial or Industrial Products and Services Needed by the Government, the Veterans Administration will be conducting cost comparison reviews at various field stations within the Department of Veterans Benefits to determine the feasibility of contracting out specific tasks to private contractors. In this notice, revisions concerning the stations involved, functional areas to be reviewed, and schedule of review dates are published for the notification of all interested parties.

Revisions of the Automated Mail Inserting Functional Area are due to test programs currently being administered at some regional offices. The completion and analysis of these procedures require a temporary delay in the initiation of the cost comparison study actions.

A study of the Centralized Transcription Activity located in the VA Central Office was inadvertently omitted from the previously published information. That omission is being corrected at this time.

The stations listed under the keypunch and microfilm categories have submitted new information which must be reviewed and considered prior to the initiation of cost comparison studies.

Only those functional activities, stations, and review dates specified in this submission reflect any change. All other information published on page 41869 of the Federal Register of August 18, 1981, remains accurate as previously printed.

For further information contact: Robert A. Jones, Chief, Records Management and Supply Liaison Division, Department of Veterans Benefits (232B), VA Central Office, 810 Vermont Avenue, NW., Washington, D.C. 20420, (202) 389-2972.

Dated: October 20, 1981.

ROBERT P. NIMMO,
Administrator.

FUNCTIONAL AREA: AUTOMATED MAIL INSERTING

Field station	Previously indicated date of review	Revised date of review
Los Angeles, Calif	Dec. 15, 1981	Aug. 31, 1982.
Philadelphia, Pa	do	Do.
St. Paul, Minn	do	Do.
Milwaukee, Wis	May 31, 1981	Do.

FUNCTIONAL AREA: CENTRALIZED TRANSCRIPTION ACTIVITIES

Field station	Date of review
VA Central Office	Aug. 31, 1981.

FUNCTIONAL AREA: KEYPUNCH

Field station	Previously indicated date of review	Revised date of review
Milwaukee, Wis	Dec. 15, 1981	Aug. 31, 1982.
Cleveland, Ohio	do	Do.
Montgomery, Ala	do	Do.
Nashville, Tenn	do	Do.
New Orleans, La	do	Do.
St. Petersburg, Fla	do	Do.
New York, NY	do	Do.
San Juan, PR	do	Do.

FUNCTIONAL AREA: MICROFILMING

Field station	Previously indicated date of review	Revised date of review
Cleveland, Ohio	Mar. 1, 1982	Aug. 31, 1982.

Functional area: Maintenance of grounds

Cemetery	Date of review
Arkansas: Little Rock National Cemetery, Little Rock, Ark	Mar. 31, 1983.
California:	
Fort Rosecrans National Cemetery, San Diego, Calif	May 31, 1983.
Golden Gate National Cemetery, San Bruno, Calif	June 30, 1982.
Los Angeles National Cemetery, Los Angeles, Calif	May 31, 1983.
San Francisco National Cemetery, San Francisco, Calif	June 30, 1982.
Hawaii: National Memorial Cemetery of the Pacific, Honolulu, Hawaii.	Feb. 28 1983.

Functional area: Maintenance of grounds—Continued

Cemetery	Date of review
Illinois:	
Camp Butler National Cemetery, Springfield, Ill	Apr. 30, 1983.
Rock Island National Cemetery, Rock Island, Ill	June 30, 1983.
Indiana: Marion National Cemetery, Marion, Ind	Aug. 31, 1983.
Kansas:	
Fort Leavenworth National Cemetery, Leavenworth, Kans	June 30, 1983.
Leavenworth National Cemetery, Leavenworth, Kans	Do.
Maryland: Baltimore National Cemetery, Baltimore, Md	Apr. 30, 1982.
Minnesota: Fort Snelling National Cemetery, St. Paul, Minn	July 31, 1983.
New Mexico: Santa Fe National Cemetery, Santa Fe, N. Mex	Mar. 30, 1983.
New Jersey: Beverly National Cemetery, Beverly, N.J	May 31, 1982.
New York: Long Island National Cemetery, Farmingdale, N.Y	Do.
Ohio: Dayton National Cemetery, Dayton, Ohio	Aug. 31, 1983.
South Carolina: Beaufort National Cemetery, Beaufort, S.C	Nov. 30, 1982.
South Dakota: Black Hills National Cemetery, Sturgis, S. Dak	Sept. 30, 1982.
Tennessee:	
Chattanooga National Cemetery, Chattanooga, Tenn	July 31, 1982.
Memphis National Cemetery, Memphis, Tenn	June 30, 1983.
Mountain Home National Cemetery, Mountain Home, Tenn.	Mar. 31, 1983.
Nashville National Cemetery, Nashville, Tenn	June 30, 1983.
Texas:	
Fort Bliss National Cemetery, Fort Bliss, Tex	May 31, 1983.
Fort Sam Houston National Cemetery, San Antonio, Tex	Apr. 30, 1983.
Wisconsin: Wood National Cemetery, Wood, Wis	July 31, 1983.

Functional area: Maintenance of buildings and structures

Cemetery	Date of review
Arkansas: Little Rock National Cemetery, Little Rock, Ark	Mar. 31, 1983.
Illinois:	
Camp Butler National Cemetery, Springfield, Ill	Apr. 30, 1983.
Rock Island National Cemetery, Rock Island, Ill	June 30, 1983.
Kansas: Leavenworth National Cemetery, Leavenworth, Kans	Do.
Minnesota: Fort Snelling National Cemetery, St. Paul, Minn	July 31, 1983.
New Mexico: Santa Fe National Cemetery, Santa Fe, N. Mex	Mar. 31, 1983.
Tennessee:	
Mountain Home National Cemetery, Mountain Home, Tenn.	Do.
Nashville National Cemetery, Nashville, Tenn	June 30, 1983.
South Dakota: Black Hills National Cemetery, Sturgis, S. Dak	Sept. 30, 1982.

Functional area: Maintenance of vehicles and equipment

Cemetery	Date of review
Arkansas: Little Rock National Cemetery, Little Rock, Ark	Mar. 31, 1982.
Illinois:	
Camp Butler National Cemetery, Springfield, Ill	Apr. 30, 1983.
Rock Island National Cemetery, Rock Island, Ill	June 30, 1983.
Indiana: Marion National Cemetery, Marion, Ind	Aug. 31, 1983.
Kansas: Leavenworth National Cemetery, Leavenworth, Kans	June 30, 1983.
New Mexico: Santa Fe National Cemetery, Santa Fe, N. Mex	Mar. 31, 1983.
New York: Long Island National Cemetery, Farmingdale, N.Y	May 31, 1982.
Tennessee:	
Mountain Home National Cemetery, Mountain Home, Tenn.	Mar. 31, 1983.
Nashville National Cemetery, Nashville, Tenn	June 30, 1983.
South Dakota: Black Hills National Cemetery, Sturgis, S. Dak	Sept. 30, 1982.

PREPARED STATEMENT OF HON. DAN MICA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. Chairman, thank you for the opportunity to submit written testimony regarding my strong concerns as to the application of the Office of Management and Budget Circular A-76 to the Veterans Administration health-care system. I represent a constituency of almost 100,000 veterans in the 11th District of Florida, and my concerns stem from the many I have heard from the veterans in my area, and throughout Florida.

As Florida's only Member of the Veterans Affairs Committee, the concerns of all veterans in Florida, with regard to Circular A-76, have compelled me to express my support for the House Veterans Affairs Committees action to exempt the Veterans Administration from Circular A-76. The area I represent contains two outpaient clinics—Riviera Beach and Broward County—and a Medical Center in Miami which serves my district. These three medical facilities will be effected by this new ruling, and could effect almost 2,000 employees.

The Miami Medical Center is in the process of advertising for keypunch persons. If these jobs, which are now filled with hospital employees, are contracted out ten government employees will no longer have jobs. Although this number is small it is an example of what could occur in all areas of employment. Like other centers, the Miami Medical Center is scheduled for a cost effective study of its food preparation, administrative, and engineering services. If these services are contracted out it could mean a loss of almost 1,500 jobs for present employees, and could be as far reaching as to effect even the top Administrator.

The VA has estimated that the cost of doing the feasibility studies could be as much as $29 million for the 4,000 studies required by the Circular A-76. It is also felt by many administrators, and employees that contracting out will lead to higher costs. After the contractor has been working for the government for two or three years there is no guarantee that his costs will not rise, and leave the government in a less fortunate position than before hiring the contractor.

Another important factor to consider is the lack of coordination between hospital administrators and contractors. The question of who has oversight over basic functions within the hospital could cause deterioration in the quality of service provided to the veteran.

In summary, the veteran who goes in for quality medical care may find a less than pleasant hospital stay. As a Member of the Veterans Affairs Committee it is our responsibility to act in the best interest of the veteran. For this reason I commend the Veterans Affairs Committee in its efforts to carefully look at all possible ramifications in conjunction with the OMB Circular A-76. I pledge my support as a Member of the Committee that I will work towards the best situation for the veteran, and the government employee.

PREPARED STATEMENT OF HON. VIRGINIA SMITH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEBRASKA

Mr. Chairman, thank you and the other members of the committee forgiving me this opportunity to state my objections to application of Office of Management and Budget Circular A-76 to the Veterans Administration health-care system.

Three VA medical centers in Nebraska are subject to the circular: hospitals in Grand Island, Lincoln, and Omaha. The center in Grand Island is in my congressional district, and serves 58 counties, including 13 in Kansas. This center, a 204-bed facility with a 67 percent annual average occupancy rate, has 286 full-time and 42 part-time employees, and served 2,778 inpatients and 18,826 outpatients this past fiscal year. Its pharmaceutical, plant maintenence, food preparation, administrative, supply, custodial, media, keypunch, chaplain, and laundry services are scheduled for studies to determine whether outside contractors can carry out such services more cheaply than in-house employees.

Although I place chaplain services toward the end of the list because that is where they appear in OMB's July 29 FEDERAL REGISTER notice on the circular, I hasten to say that their inclusion puzzles me. I do not know of any commercial vendor of spiritual services, although perhaps OMB knows of some sort of subscriber "Dial-a-Prayer."

Scores of employees and patients at the Grand Island Medical Center have written or called me to express their opposition to OMB's application of the circular not only to their hospital but also to all of the facilities administered by the VA Department of Medicine and Surgery. On their behalf and in the interest of all the veteran population of the Third District of Nebraska, and even those from the

northern counties of Kansas, I would like to work with you to see that the Department of Medicine and Surgery is exempted from this circular.

I object to the circular for two main reasons. First, the circular's application to the Department of Medicine and Surgery is based solely on the goal of saving money. As a member known for frugality, particularly—but not exclusively—when taxpayers' dollars are being spent, I am as anxious to cut the federal budget as is OMB Director David Stockman. However, when the health—the very lives—of veterans are at stake, it is crass to consider cost alone. Contracting out seems to me to be not only counter-productive to the delivery of quality health-care services but also highly questionable in terms of cost-effectiveness.

Moreover, I understand that the studies alone—on a nationwide basis—could cost nearly $30 million, with the funds taken from money allotted for health services to veterans. How may renal dialysis procedures, chemotherapy administrations, and fitting of prosthetic devices could be paid for with such funds?

Second, the circular's application to the Department of Medicine and Surgery undermines the integrity of the VA. In fact, it violates Title 38, the public law governing the VA, by taking authority from the Department of Medicine and Surgery for determining rules, procedures, and limitations on the delivery of services in the VA health care system. This authority clearly extends to the contracting-out of services, as indicated in Public Law 94-581. This usurpation of authority, by an agency of government that has no knowledge of or experience with the health needs of veterans, clearly goes against congressional intent.

Mr. Chairman, extension of this circular to the VA is a challenge to a health network that has been carefully and deliberately nurtured for many years by this committee and its counterpart in the Senate. For the 30-year-old Grand Island Medical Center in my district, it is a threat both to the quality of care for present and prospective patients and to the livelihoods of dedicated employees. I congratulate you and the members of the committee for meeting the challenge, by insisting on the Department of Medicine and Surgery's jurisdictional rights. As the representative of the Third District and as a member of the Committee on Appropriations, which determines appropriations for the VA, I pledge to help you in every way to see that these jurisdictional rights are maintained.

PREPARED STATEMENT OF CLYDE C. COOK, ASSISTANT DEPUTY ADMINISTRATOR FOR PROCUREMENT AND SUPPLY, VETERANS' ADMINISTRATION

I appreciate the opportunity to appear before this committee to provide you with information concerning the implementation of Office of Management and Budget Circular A-76 relating to contracting with the private sector for services presently performed in their entirety by Veterans Administration employees. On July 14, 1981, the agency's position was presented to the Subcommittee on Oversight and Investigations of the House Veterans Affairs Committee.

That July 14 testimony provided the background behind OMB Circular A-76 and noted that the Veterans Administration has an inventory of functions classified as commercial/industrial amounting to approximately 3,271 activities employing 36,980 personnel, with an annual operating cost of $620 million and a capital investment of $432 million. As we noted in July, this is one of the largest inventories of commercial/industrial type activities in the federal government.

Since completing the inventory and analyzing its contents, we developed a directive within the Veterans Administration which implements OMB Circular A-76. This publication is VA Circular 00-81-32, July 30, 1981; that implementing circular established an internal management structure for undertaking A-76 reviews and provides specific guidelines with regard to the process itself. In addition, on July 29, 1981, and in August 1981, we published review scheduled for the Department of Medicine and Surgery and the Department of Veterans Benefits in the Federal Register. We have received no instructions from the Office of Management and Budget since April 1981, regarding implementioan of Circular A-76.

The circular noted that the magnitude of the review program requires that it be decentralized to the maximum degree feasible. Accordingly, heads of field activities were directed to organize management teams to conduct the reviews of the functions to be studied. Because of the importance of the review process, the circular provides that each team will be headed by a senior management member of the facility staff and will include representatives of other specialty areas whose expertise is involved; for example, the activity official, the Personnel, Supply and Engineering Services.

The reviews would be accomplished by developing work statements for each individual commercial/industrial activity under review. Under the procedure notice would be placed in the Commerce Business Daily to prospective interested firms to

advise them of the activities being considered for review. If two or more responsible firms indicate willingness to compete for a contract to provide the commercial/industrial activity, a solicitation would be developed, issued to all known prospective bidders and a cost analysis made of government function. This cost analysis and commercial firms' bids would be sealed and retained until the specified opening date. On that date, both the government's cost analysis and any bids would be evaluated. If there are two or more responsible, responsive bidders, their bids would be analyzed and compared with the government cost study to determine which is the lowest overall cost. The VA circular specifically named individuals who would be responsible for reviewing and approving decisions to contract or continue in-house. An appellate process is provided.

The cost comparison process specified in Circular A-76 is quite detailed and complex. For this reason, we have conducted two major training seminars for a total of over 550 personnel from our field facilities who could perform facility studies. These training sessions focused upon the cost analysis aspects of the A-76 process and the intricacies of the specified cost procedures. We have plans for other training sessions which would focus on the various disciplines directly involved in the cost analysis process; for example, the role of Personnel in projecting reduction-in-force related costs and attempting to minimize employee impact, the Contracting Officer's role in the bidding process and in contract monitoring and administration, the Fiscal Officer's role in the provision of cost accounting figures. It has been our intention to publish other pertinent data and guidelines as we gain more experience in the A-76 process.

Further cost comparison studies in DM&S would appear to have been effectively eliminated by the recently passed "Veterans' Disability Compensation, Housing and Memorial Benefits Amendments of 1981," assuming that measure is signed into law. Section 601 of that measure proscribes the use of funds appropriated for medical care, medical and prosthetic research and medical administration and miscellaneous operating expenses for conducting A-76 cost comparison studies. Though some studies could conceivably be funded out of VA's general operating expenses appropriations, we believe the practical effect of this provision is to prevent VA from further implementing OMB Circular A-76 in the Department of Medicine and Surgery.

Notwithstanding discontinuation of any further Circular A-76 reviews in the Department of Medicine and Surgery, there are other commercial/industrial activity areas in the VA. The inventory of commercial/industrial activities outside the Department of Medicine and Surgery lists 523 individual functions affecting 1,806 full time employees. These activities are distributed among the Department of Veterans Benefits, Department of Memorial Affairs and to a lesser extent, staff offices in the Veterans Administration's headquarters. These activities include such functions as centralized transcription, keypunching, grounds maintenance at cemeteries, gravedigging, automated mailing and some architect/engineering services.

The Veterans Administration has exempted some of the activities in its inventory from further review under A-76. These exemptions for the most part reflect the need to maintain a minimal level of in-house capability where a short response time is necessary and unavailable through contract. Exceptions have been granted for such activities as architect-engineering services, certain audiovisual functions at the headquarters and vocational rehabilitation counseling of beneficiaries. The right to exempt identified commercial/industrial type activities from A-76 may be exercised by the Administrator where it is clear that a conversion to contract would cause serious disruption of a government program. Exemptions granted to date outside the Department of Medicine and Surgery have generally reflected this concern. The threat of a strike or work action by contractor employees has not been identified as the basis for any of these exemptions. If such actions were to occur, it would be much more critical in some areas than others.

I would like to emphasis the general policy of the Veterans Administration on reliance upon the private sector. We currently contract for an extensive amount of services. In a procurement budget of a little over $2 billion, approximately $700 million is for services which are classified as commercial/industrial. This $700 million worth of contracted services approximates the annual operating costs of our current in-house inventory of commercial/industrial activities. For example, in Fiscal Year 1981, we contracted for approximately $73 million for travel of beneficiaries including ambulance and hired car services, approximately $9 million for automated data processing related services, $72 million for maintenance and repair services including upkeep of roads, walks and grounds, $15 million for veterans counseling services, $23 million for the repair of equipment. An illustration of the mix of in-house and contract services used within the Veterans Administration can be found in our plant maintenance function. Of the $622 million expended nationwide in fiscal year 1980 for maintenance and repair and operation of our 172 health

facilities, $292 million was expended through contract services. Again, of the $42,100,000 in costs for biomedical engineering repair, maintenance and inspection, $20.5 million was for contractual services. Virtually all of the $130 million expended for non-recurring maintenance is for contract services. These illustrations are indicative of the Veterans Administration's general reliance upon the private sector as specified in OMB Circular A-76. We have a mix of in-house and contract services in many of our functional areas already. Generally, there has been a trend toward increased reliance upon the private sector for such functions as ambulance service, transportation, garbage and refuse collection, insect and rodent control and plant maintenance. We expect this trend to continue, A-76 notwithstanding, provided it is deemed beneficial from both a management and an economic perspective. We will continue to strive to increase both efficiency and economy of operation. However, as is reflected in Circular A-76, the judgment as to which services are to be performed in-house should be based on consideration other than just cost factors, such as the availability of satisfactory service and the relative isolation of many of our facilities with the concommitant nonavailability or limited availability of prompt service to maintain critical operations.

This concludes my statement, Mr. Chairman. I will be happy to answer any questions.

[Memorandum]

MARCH 21, 1980.

To: Chief Medical Director (13).
From: General Counsel (023).
Subject: Draft of VA circular 00-79—Policies for acquiring commercial or industrial products and services needed by the government.

1. You have requested our opinion regarding the application of OMB Circular A-76 dated March 29, 1979, to Department of Medicine and Surgery (DM&S) activities. Circular A-76 prescribes "Policies for acquiring Commercial or Industrial Products and Services Needed by the Government." Because attachment "A" to the circular lists among its other examples of commercial and industrial activities, health services of almost every kind, your question and concerns are well founded.

2. In attempting to reach a rational understanding of the application of the circular to DM&S operations, certain concepts fundamental to the operation of our system of Government must be considered. First, the President and the executive branch of the Government administer laws enacted by the legislative branch of the Government. Thus, any Executive order or other Presidential directive issued in carrying out the responsibility of the executive branch to administer the laws must be consistent with the law being administered. Second, when Congress enacts a law specifically directing an agency in the executive branch to take a prescribed course of action, that law is generally deemed to preempt the field.

3. In applying Circular A-76 to DM&S activities, careful attention must be given to the specific language and intent of the circular, itself, and the accompanying transmittal memorandum. In that transmittal memorandum it is stated that the circular reaffirms the general policy of relying on the private sector for goods and services, while recognizing that certain functions are inherently governmental in nature and must be performed by Government personnel. The transmittal memorandum also points out that in those areas not inherently governmental in nature, relative cost must be given appropriate consideration in making decisions between in-house performance and contracting out. The circular reiterates the basic premise that in a democratic free economic system, the Government should not compete with its citizens and, thus, follows the general policy of relying on competitive private enterprise to supply the products and services it needs. Bulletins and circulars of OMB have articulated this policy in 1955, 1957, 1960, 1966, 1967 and 1976, before this latest version in 1979.

4. In defining the scope of the circular, OMB in paragraph 6.b. has specifically exempted governmental functions which are defined in paragraph 5(f) as a function "which must be performed in-house due to a special relationship in executing governmental responsibilities." Categories of such functions include "[d]iscretionary application of Government authority . . . as in management of Government programs requiring value judgments, as in directing the national defense; . . . selection of program priorities . . . ."

5. Given the fundamental concepts of our form of Government discussed above, the language discussing the intent of the circulars, the history of OMB pronouncements on contracting out, and the language of the latest circular relating to its

scope, we believe it abundantly clear that the basic provision of health care by DM&S is not significantly impacted by the latest version of OMB Circular A-76.

6. Under current statutes, OMB cannot direct the VA to contract out its basic health care function. The Congress in enacting Public Law 79-293 preempted this field when it created in the VA a DM&S under a Chief Medical Director, having as its primary (i.e., governmental) function to provide a complete medical and hospital service for the care and treatment of veterans. This is a national policy established by the Congress, and can be changed only by the Congress. Indeed, President Carter's letter of August 27, 1979, to Senator Alan Cranston recognized this and voiced the President's continuing support for such policy.

7. Moreover, we believe that Congress, in establishing specific authority for certain limited types of contracting by DM&S, was clearly aware of the general restrictions on contracting authority within DM&S. That the contracting out policy under title 38 is separate and distinct from that of Circular A-76 is given clear expression in section 621 of title 38 which authorizes the Administrator to prescribe: (1) rules and procedures governing furnishing of hospital, nursing home and domiciliary care and (2) limitations in connection with the furnishing of such care. Chapter 17 of title 38 sets forth in detailed provisions the Department's role as a direct provider of hospital, nursing home, domiciliary, and medical care. By its terms chapter 17 poses specific restrictions on contracting for the provision of those services. In qualifying the scope of the VA's authority to furnish those modes of care to eligible veterans, the statute has long provided that such services could only be furnished "within the limits of VA facilities." VA facilities were defined in chapter 17 to include private facilities with which the VA may contract. But such authority is available only for very limited classes of beneficiaries. There has long been a specific limitation on fee-basis care, for example, particularly where it involves care for a nonservice-connected condition. Furthermore, in Pub. L. No. 94-581, Congress, in responding to the rapid growth of VA fee-basis medical care, imposed still further limits on such contract care. The authorizing committee which reported out the legislation that formed the core of Pub. L. No. 94-581 described the amendment as making clear "that the VA may contract for fee-basis service only when VA or other Federal hospitals or clinics 'are not capable of furnishing economical care because of geographical inaccessibility or of furnishing the particular types of care or services required.' The effect of this new language is to limit the authorization of fee-basis service for service-connected or nonservice-connected disabilities to those situations when regular VA hospitals and clinics (or other Federal facilities) are genuinely unable to provide the needed services themselves." SEN. REP. NO. 94-1206, 94th Congress, 2d Session, p. 75.

8. VA care is by statute defined to exclude contract care except in specified areas. In providing specific limits on contracting for hospital and medical care, Congress has imposed an exclusive restriction. In other words, the very statutory scheme of chapter 17 supersedes and excludes any application an OMB circular on contracting out might have on the VA as a direct provider of medical care.

9. Title 38 also establishes specific, exclusive policy on contracting in the areas of research and insurance (§ 4101), central administration of house staff stipend and benefits (§ 4114(b)(3)), scarce medical specialist services (§ 4117), staffing of Regional Medical Education Centers (§ 4122), and specialized medical resources (§ 5053). Because the VA is directed or authorized by law to contract in these specific areas, we believe Congress has established a rationale for such contracting different, in most circumstances, from the rationale behind Circular A-76. Under A-76 the intent is that the Government not compete with the private sector and that, in nongovernmental functions, cost-effectiveness must be a criterion for decisions on contracting out. On the other hand, under title 38, the underlying policy is to provide a complete and separate medical and hospital service for the care and treatment of veterans. Where conflict arises between A-76 guidelines and specific title 38 mandates or authorities, title 38 must prevail. In other areas where Congress has not been specific, we believe the VA and DM&S must follow the directives of A-76.

10. In your memorandum you specifically pose the question "whether the maintenance and management of DM&S facilities be solely by VA personnel." We believe that Congress intended the management of DM&S facilities and the direct provision of health care, to be a governmental function, but specifically authorized contracting out where deemed necessary to ensure that the VA could meet its mission of providing a complete medical and hospital service. The many specific provisions in title 38 relating to employment preclude any other conclusion. See 38 U.S.C. sections 4103, 4104, 4111, 4114, all relating to employment of personnel to operate the DM&S. See also 38 U.S.C. sections 4105 (qualifications of certain employees); 4106 (exemption of qualifications from Civil Service requirements and a probationary period); 4107 (rates of pay); 4108 (authority of Administrator for personnel

administration, hours and conditions of employment, etc.); 4113 (travel expenses of employees); 4115 (authority of Chief Medical Director relating to employment in DM&S).

11. As regards the specific question cited in the above paragraph, however, it is not clear what you may have contemplated in asking whether "the maintenance" in addition to the "management" of DM&S facilities is to be solely by VA personnel. We note that the phrase "management and maintenance" appears, albeit in a somewhat more specific context, in the text of Circular A-76, March 29, 1979. Paragraph 5.f of the circular which defines the term "governmental function" includes among the categories of such functions "[i]n-house core capabilities in the area of research, development, and testing, needed for technical analysis and evaluation and technology base management and maintenance." However, as distinct from the management of the Department and its facilities, as well as the direct provision of medical care, we question whether the "maintenance" of those facilities, if you are referring to routine building and grounds maintenance, for example, can indeed be considered exempt from A-76 coverage.

12. We have not attempted in this memorandum to delineate with specificity which areas are or are not covered by OMB Circular A-76. As a general matter, however, we believe that, as distinct from the Department's direct medical care activities and managerial role, support activities (not directly related to patient care and not unique to the Department) for which VA might contract under section 213 of title 38 would be covered by A-76. For example, we consider general maintenance, grounds care, and laundry service, as among those functions to which A-76 would apply. We will, of course, be pleased to discuss the applicability of A-76 to specific services which might not appear to fall clearly on either side of the line we have attempted to draw.

13. In summary, we believe differing policies are operative in OMB Circular A-76, and in the management of DM&S. The general policy that the Government not compete with the private sector for commercial or industrial products and services underlies A-76. A national policy to provide, as a governmental function, a complete medical and hospital service for our Nation's veterans underlies title 38 and DM&S operations. To apply the rules of A-76 to the basic medical care operations of DM&S, where specific statutes establish the parameters of the mandated governmental function, cannot be justified either legally or on a policy basis. Thus, with the general exception noted above, we believe A-76 does not affect the day-to-day medical care operations of DM&S as delineated in title 38, United States Code.

GUY H. MCMICHAEL III.

PREPARED STATEMENT OF HENRY B. GONZALEZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

I am Henry B. Gonzalez, and it is my privilege to represent the 20th Congressional District of Texas.

My area is served by the Audie Murphy Veterans Administration Hospital, and it is the newest, finest such hospital in Texas. I want to stress to the Committee that construction of this hospital was among my very first priorities when I was elected to Congress. I appealed to President Kennedy to plan for the hospital, I fought for its authorization, and worked for its construction. It was my suggestion that the hospital be named in honor of Audie Murphy, a fellow Texan and authentic American hero.

The Audie Murphy Hospital is an installation I am proud of; from the beginning of my Congressional service, it has been a high priority with me. First of all, there is a bigger concentration of veterans in South Texas than almost anywhere else in the country. Having the Audie Murphy Hospital in San Antonio brings fine medical care close to home for those veterans—and they deserve that. Second, San Antonio has built a first class medical center, of which Audie Murphy is a part, and I might add, a critically important part. No veteran population in America has better medical care, closer to home, than our South Texas veterans.

Caring about that hospital as I do, caring about veterans as I do, anything that threatens the quality of Audie Murphy's medical service is a great concern of mine. That is why I am here today. I do not believe that contracting out the so-called commercial and industrial functions at Audie Murphy—or any other VA hospital—is in the interest of veterans or the maintenance of first class medical care.

I am aware that many hospitals do contract for many services. I am also aware that in such hospitals the care is increasingly less personal, and that there are genuine problems of creating, or keeping up, the team concept of medical care when some personnel are on one team and others on another team. The ideal kind of

hospital care is care organized around personnel who see themselves as part of one unit—and that simply cannot happen when some people work for the hospital and others work for contractors. From the point of view of patient care, I do not believe contracting out is in the interest of VA, and certainly not in the interests of veterans who look to VA for specialized, compassionate care—care for which they have paid more than a full price.

The Office of Management and Budget argues that the government can save money by contracting. I doubt that this is true, but if it is true, any such savings have to come out of lower employee pay and benefits, or must come out of a lower level of service. Chances are that whatever savings are realized would come about only by reduced levels of service and care, and lower employee pay and benefits.

I hope that the Committee will look carefully at both these so-called potentials for saving.

It would be unacceptable and catastrophic to save money at the expense of quality patient care and service. Hospitalized veterans deserve—and have earned—the finest medical care we can provide. We would break faith with them if in the guise of some dubious savings, we degraded them by degrading their care. We would dishonor ourselves by accepting any such scheme.

Second, considering the question of savings through reduction of pay and benefits to employees, I don't think this is acceptable. If pay and benefits are too generous, let the Administration come and argue that point. But don't accept a backdoor approach to cutting pay and benefits to employees who for the most part are veterans themselves—employees who are skilled and dedicated, and who have long and honorable service.

Generally speaking, contracted government work under the A-76 Circular affects labor-intensive types of work—the lowest jobs the government has to offer. And from my experience, what happens when a job is contracted is that the affected employees simply end up doing the same jobs in the same place, but for much less pay and for much lower benefits. They lose retirement credit; they lose health benefits; they lose leave policies; they lose sick leave—and having lost all that, you can imagine how good their morale is. No employee, no matter how dedicated, can go through that kind of degradation and still have the same morale and desire to serve that he had before. Yet, that is exactly what we invite by the working of the contracting procedure.

The whole idea of the A-76 contracting procedure is to skin government employees. It is to subvert the whole range of pay and benefits that the Federal government itself has deemed reasonable and desirable—pay and benefits that we in the Congress have approved. That is why I say, if the argument is to cut employee cost, then let the Administration be straightforward and come up here to tell us just where they think Federal pay policy is wrong and ill-advised. Let them tell us why employees should lose their retirement credits. Let them tell us why employees should be expected to perform well after having been dumped, duped and demeaned. Let them tell us how it is that patient care is going to be enhanced by that kind of procedure.

The Committee should be aware that whenever any contractor is so unwise as to start paying his employees a little more than the bare minimum, he most likely will lose out when contract time comes up again. The A-76 procedure creates a treadmill, guaranteeing that those employees who are on the bottom of the heap, stay on the bottom of the heap. It creates a sytem whereby all incentives—as far as the bulk of employees are concerned—simply vanish.

Year after year, I have seen the argument that contracting out is a good thing. Year after year, I have seen the hard evidence that it is not. It would be a mistake to contract VA hospital services, and I urge the Committee to oppose this current attack—which is not merely an assault on government employees—but in reality an attack on the whole concept of government-provided medical care for veterans. Mr. Stockman is not a veteran; he does not care. But millions of Americans are veterans, and they do care.

The Committee cannot let this challenge to the VA medical care system go unchallenged.

PREPARED STATEMENT OF MS. MARY HELEN MCGUIRE, CHIEF, DIETETIC SERVICE, VA MEDICAL CENTER, WASHINGTON, D.C.

An informal survey of the majority of the local hospitals in the metropolitan area of the District of Columbia resulted in finding that Food Service contractors do not employ the food service employees at any of the hospitals—see attached Chart (1).

Telephone contacts resulted in the following findings:

1. Director of Dietetic Service--Rush/St. Luke/Presbyterian Chicago, Ill., 958 Beds, Dietetics was low bidder and service remained in-house. Bid stated the food service employees were to remain as hospital employees; ARA was closest bidder but their management bid figure was so high they lost the bid.

2. Society Director, American Society for Hospital Food Service Administrators; American Hospital Association, Chicago, Ill. "In checking around", the Society Director found the contractors were not interested in employing food service employees—only the management aspects of the Dietetic Service.

3. President, New Jersey Dietetic Association. This individual is also Director of Dietetics in a private hospital. She stated contractors are "brought into" hospitals for a variety of reasons but it is usually because of a management problem in Dietetics such as inability or reluctance to terminate poor employees or very weak management. Food Service Workers remain on the hospital payroll.

4. Chief, Dietetic Service, VA Medical Center, Houston, Texas. In conversations she had with dietitians in the area she found contractors are not interested in employing food service workers. Hampton, Virginia. Had not discussed this with many individuals in area but what knowledge she had was that contractors prefer to not employ food service employees.

An article in Modern Health Care, July 1979 by Sheila L. Simier discussed the major food service contractors. Some of the highlights are: "Marriott Corp. provides a director and four assistants to help feed 1500 employees and up to 17,000 patients annually * * *." "ARA's expertise was needed * * *; it brought in a director and a dietitian-* * *." "Saga Corp. links its management feed to a guaranteed budget * * *." "Macket will give the hospital whatever it wants * * *."

Consensus of findings and opinions was that food service contracts are food service management companies who are not employers of food production and service employees but contract for managing a Dietetic Service.

(1)

LOCAL SURVEY

CONTRACT FOOD SERVICE

WASHINGTON D.C. AREA

HOSPITAL	Contractor	Employ Mgt. Only	Employ Product. Serv. Employees	Number of Beds
D.C.				
Capitol Hill Hospital	Marriott	Yes	No	211
Children's Hospital	Marriott	Yes	No	240
Georgetown Univ. Hospital	Marriott	Yes	No	442
Greater Southeast Hospital	Marriott	Yes	No	400
Providence Hospital	ARA Discontinued	Yes	No	392
Washington Hospital Center	SAGA	Yes	No	804
Baltimore, Md.				
Johns Hopkins Hospital	SAGA	Yes	No	1151

PREPARED STATEMENT OF ALBERT L. CONDINO, ADMINISTRATOR, OUR LADY OF VICTORY HOSPITAL, LACKAWANNA, N.Y.

Mr. Chairman, thank you for giving me the opportunity to testify regarding my experience with contracting for services previously performed by hospital employees.

I am a graduate of the University of Toronto's School of Hospital Administration, completing my hospital administration residency at the Millard Fillmore Hospital in Buffalo, New York in 1961. On completion of said residency, I was appointed assistant administrator at Mt. St. Mary's Hospital in Niagara Falls, New York, a general acute-care hospital of approximately 200 beds. This hospital had entered into a contract with a housekeeping contract service company a few years prior to my appointment.

Being a native of Niagara Falls, I was acquainted with many housekeeping employees and their families. It was not long after my appointment that many of the employees came to me to complain about the cleanliness of the hospital which they said had deteriorated since the contract service company took over. These were employees who formerly worked for the hospital and who were employed by the contract service company pursuant to the provision of the agreement.

Having been educated in a school of hospital administration with a strong emphasis on organization and management, and a philosophy that questioned how a profit-making company could do a better job at a lower cost than a not-for-profit organization, I took this complaint to the administrator and asked her what she thought about this contract service company's performance.

The administrator of the hospital said that she too was not satisfied with the level of performance of the contract service and asked me to investigate. In conducting the investigation, I took into account the accepted standards of housekeeping, as well as the cost of maintaining an effective housekeeping program.

I interviewed department heads and also chiefs of medical departments, and without exception, they expressed a dissatisfaction with the cleaning as compared with the cleaning formerly performed when the hospital operated its own housekeeping department.

I also conducted cost-comparative studies and found out that we were not operating a low-cost housekeeping service as compared with other hospitals in our bed-size in Western New York.

As a result of our findings, we retained a qualified housekeeping director and established a reorganized housekeeping department. In so doing, we were able to provide housekeeping services acceptable to our staff at an established standard at a lower cost than what we were paying to the contract service company.

Following my several years as an assistant administrator at St. Mary's Hospital, I worked as a hospital administration consultant with the New York State Department of Health. During my three years with the Department of Health, I had occasion to survey many hospitals and nursing homes in both the Syracuse and Rochester regions of the state. Our survey team consisted of a physician, nurse, sanitarian, nutritionist, and administrator. We found that the departments operated by outside contract services were not functioning at the same level of performance as those operated by hospital personnel.

On leaving the State Health Department, I was appointed assistant and later became associate administrator at a diocesan hospital located in the inner city of Buffalo whose food service department was managed by contract service.

Shortly after my appointment, I was greeted by complaints from patients, doctors and personnel about the food being served by this contract service company.

I investigated the complaints, and they were substantiated. I also conducted a study of the cost of operating the dietary department, and it was determined that the hospital could operate its own department at a lesser cost because the cost had increased substantially from the time the hospital entered into its contract with the contract service company.

At that hospital, the Emergency Hospital, I left prior to the final decision which was made to discontinue the contract service and for the hospital to take over the management of the dietary department.

I left the Emergency Hospital to become the administrator of the Our Lady of Victory Hospital, a 306-bed general acute-care hospital in the city of Lackawanna, New York, a position I have held since 1971.

In 1960, Our Lady of Victory Hospital had contracted with a housekeeping service. Following my appointment, I undertook a survey of the housekeeping performance and also conducted a cost-comparison study which resulted in our discontinuing the contract service in 1972.

In summation, from my experience, I conclude that:

1. A profit-making contract service cannot perform at the same level at a lower cost regardless of what their multitude of brochures and salesmen may say. They can begin with a "sweetheart contract" just to get their foot in the door, but that is where it ends.

2. The management control over a contract service department is not the same as the direct control over your own hospital department which is so essential to administering an effective hospital operation.

3. The morale of the contract service employees is lower because their wages and benefits are significantly less than the hospital employees' wages and benefits because of the need for the contract service company to show a profit.

4. The hospital administrator who goes to contract services is copping out of his/her responsibility to the institution as its chief executive officer to manage an efficient and effective hospital.

I am willing to answer any questions that the committee may wish to ask me.

Thank you.

PREPARED STATEMENT OF GARY MULLENNIX, PRESIDENT, HUNTINGTON LABORATORIES, INC., HUNTINGTON, IND.

My name is Gary Mullennix, President of Huntington Laboratories, Inc. of Huntington, Indiana. Our company manufactures and sells housekeeping products to the institutional market. We also sell our products to some 2,500 hospitals across the United States and are well known within the trade.

I want to thank the Committee for the opportunity to testify on the merits of the proposal for using outside cleaning contractors under A-76. I hope my efforts will be of value.

As I understand the proposal under A-76, I must say that no businessman would ever knowingly expose himself to the risks inherent in such a scheme. Turning over a large, costly and critical function to an outside contractor whose primary goal is to produce a profit sets up a constant conflict of interest.

The additional peril caused by surrendering all VA supervisory and housekeeping personnel into the direct employment of the contractor is frightening. The result can only be a total loss of control over the delivery of quality health care. This scheme further ensures a dramatic rise in housekeeping costs because it removes any real options the VA might have to return to an in-house operation or to employ another contracting firm.

The reason is quite simple. The threat of the then current contractor's removal of all "his" housekeeping employees means the VA would have to accept virutally any terms offered. Each contract renewal would be tantamount to a strike. No housekeeping duties would be performed and the delivery of Health Care would cease.

The hospital's only recourse would be to magically produce—instantly—a fully trained housekeeping and supervisory staff. It would be impossible.

There are no options worth exploring. This proposal is an idea which should be stopped here and now.

In order to further support the argument against the proposed A-76 and the chance the VA might go to a modified version that would still use contractors who would supply only the top supervisory and management, it is necessary to cover a number of other points.

I first began to become knowledgeable about the phenomenal profit in housekeeping contract management in 1977 when we were able to look at the proposals presented to the University of Michigan Medical Center, Ann Arbor. ServiceMaster, A.M.S. and Crothall were all involved.

The proposals made it quite clear that the competitive situation had finally come down to money. All three were proposing enormous savings. ServiceMaster won out.

In order to make these enormous savings, all three proposed staff cuts in the 40 percent range. In Exhibit One (1), pages 1 & 4 are the very real concerns expressed by the building service director over the staffing reduction.

His fears were justified, as union problems did ensue—Exhibit Two (2). Also, our latest information is that the University is seeking to get out of the contract.

But the profitability on this contract was staggering—Exhibit Three (3). After recovering all costs of salaries, supplies, relocation and even parking, ServiceMaster received a compounded fee of 7.4 percent of all the wages paid by the hospital to its housekeeping employees, plus 7.4 percent of all the expenses the hospital reimbursed ServiceMaster. Since this was a contract that was to exceed $3,000,000, a fee of $220,000 net of all expenses seemed incredible.

MYTHS REALITIES

It has been necessary to go through the above process so that we can clearly debunk a favorite myth that hospital contact management will save the hospital money.

There is nothing the contractor can do that the hospital could not do. The illusion of money saved comes solely form the singular act of reducing the number of employees. 95 percent of the cost of a housekeeping department is labor.

If a hospital is truly overstaffed, the hospital can achieve the reduction in cost by reducing the number of positions and save the contractor's enormous fee by doing so. It is administration's job to see that all departments are adequately staffed. Passing the buck to an outsider is both excessively costly and is an abrogation of the duties of top management.

Another myth is that the outsider can do the job as well or better than it is currently being done. Let's remember for a moment that in order to make good on the promise to save money and provide themselves a fee, they must cut the labor force.

This cut, which comes quickly, creates havoc among the remaining employees and among the hospital department heads, who suddenly find themselves with housekeeping tasks. And, either the department takes on these new tasks, or else they are not done!

NURSING SERVICES OFTEN FINDS ITS WORK LOAD INCREASED

The contractor knows this reassignment can cause problems, and gives its housekeeping managers instructions to head of trouble before it starts. Exhibit Four (4) is such an example and poses the problem of an operating room supervisor who might complain when suddenly she finds there are no housekeepers to clean the surgical suites during the day between operations.

Exhibit Five (5) is a study we came across which neatly summarizes a study performed for the Albert Einstein Hospital. The quality of contractor managed housekeeping was so poor the hospital had a professional engineer study the alternatives. The conclusion was that even with two additional contractors bidding, it was clear that it was less costly to do the job in-house. They terminated their contract with Crothall shortly afterward.

The question of why hospitals go to a contract management company naturally arises. Exhibit Six (6) answers the question pretty well. It is the results of a national survey of hospitals that had a housekeeping contract and since cancelled. It was prepared by Dr. Joseph Brown and published in HOSPITALS, July 16, 1981.

Basically it says that the hospital is faced with both a managerial problem and a notion that costs should be reduced. The sales pitch employed by the contractor is well structured, well rehearsed and says simply: "Don't worry any longer. We have an endless supply of highly trained housekeepers who know all the answers."

Apparently the siren-like tune works well, but as the survey points out, reality sets in and they cancelled when it became obvious they could do the same job for less money and have more control doing so. Exhibit Seven (7) is a listing of just the hospitals we know have discontinued these outside services. The actual list is, no doubt, many times longer.

There are many other serious problems that need to be addressed in considering the use of an outside contractor. There are quite a few other exhibits we won't reference, but which should be studied. For now, let's pick a few of the more obvious problems.

1. Teamwork.—An outside contractor whose goal is to make a profit cannot build a loyal team. Since the employees report to the manager of an outside company who can fire them, their loyalty to the hospital evaporates. When a conflict of interest arises, they will side with the contractor.

Also, rapid termination of housekeeping employees to achieve the desired staffing level will sow the seeds of discord that will grow for years.

Finally, the contractor's manager will not cooperate with the other managerial team members when a conflict arises. They survey (Exhibit 6) makes this quite clear.

2. Management Development.—As businessmen, we know that our future success is dependent upon the quality of the managerial team we assemble and train. Our responsibility to the corporation is that, should we vanish tomorrow, or any one of our departmental heads vanish, the organization moves along without a hitch. It is poor management practice to abrogate that responsibility to an outsider over whom we have little control.

3. Loss of Supervision.—In most contracts, the hospital agrees to not hire away the management staff of the contractor. This becomes a strong argument against

getting out of the contract, since to do so means the hospital has not trained supervisors on hand. No hospital should put itself in this position of weakness.

4. Loss of Accountability.—Employee personnel records, housekeeping procedures, reports on inspections, condition of equipment, inventory and requirements of supplies are all the property of the contractor. We caution any hospital contemplating leaving the contractor to make every effort to regain this material before notifying the contractor of the hospital's intention. Again, this occurs because the contractor is an outside agent, not an employee of the hospital. The loyalty is outward.

SOLUTION

The solutions to the problems faced by hospitals require that administration make the effort to get involved in one of its biggest cost areas.

Housekeeping is not a difficult task. It takes management, however, someone who genuinely cares about the delivery of quality health care. And, someone who has the personal skills to do the job.

For years, we have recommended recruiting, hiring and training people for housekeeping management who have demonstrated managerial ability to identify and solve problems, handle a large group of diverse people and work well with the other professionals in the hospital. Too often, the administration thinks that a director of housekeeping should be, first, a housekeeper, fully trained in procedures. Nothing could be further from the actual need.

Outside consultants whose purpose is to come in for a limited amount of time to help the manager of housekeeping implement proven systems and procedures are readily available, are cost-effective and cause no disruption in the hospital.

Private companies, like ourselves, offer a full range of training programs available through highly trained representatives.

The solution to providing high quality housekeeping is readily available. It takes an effort and commitment by administration to get the job done. The tragedy is to mistakenly pass the responsibility to an outsider who can only do what the hospital could do for itself. And, the hospital can do it at a much lower cost while delivering the highest quality health care.

GARY A. MULLENNIX.

EXHIBIT 1

THE UNIVERSITY OF MICHIGAN, HOSPITAL BUILDING SERVICE DEPARTMENT

To: Alexander H. Williams.
From: Kenneth L. Bunn.
Date: August 9, 1977.
Subject: Building Service Evaluation of Contract Housekeeping Proposals.

Reference Memo, subject as above, dated July 21, 1977. This memo is in five (5) parts covering the three (3) proposals with respect to the following areas: I. Cleaning Specifications; II. Equipment to be Used; III. Staffing; IV. Supplies to be Utilized; and V. Quality Control Program.

I. CLEANING SPECIFICATIONS

All three companies presented cleaning specifications.

A. AMS—presented several very detailed examples covering cleaning of patient rooms and cleaning of equipment; cleaning frequency charts covering 26 cleaning functions for 63 different room categories.

B. Crothall—covered in detail 15 different housekeeping specifications for 35 different room categories in the Main Hospital, 33 for NPI and CPH and so forth for other areas for a total of 40 pages regarding specifications.

C. ServiceMaster—presented five to six groupings of specifications for each hospital division covering from 51 to 63 different cleaning functions.

Summary.—Due to the magnitude of material presented and the fact that all three sets of specifications were presented quite differently, it is not possible in the limited time provided to make an item-for-item comparison for the three sets of specifications.

Generally speaking the frequencies are in accordance with current desired frequencies. Critical cleaning functions have been enhanced by both Crothall and ServiceMaster by including check-off forms.

B. Crothall—is slightly better with 13 supervisors. One thing needs to be mentioned at this time. Basically all three of the companies operate out of a central department. Crothall even proposes a project team of custodians for major project work. There is no doubt that both staffing and dollars can be reduced if one's desire is a *Centralized* Department. Yes, University Hospital's Building Service Department attempted to work out of this position for over two years and the major problem was who do I work for. The Administrator really did not have total control over their division.

C. ServiceMaster—presented four separate proposals stating that they have experience with a decentralized mode of operation. They no doubt have the most experience and the largest backup organization. Their proposed supervisory staffing will work the best of any of the proposals.

Summary.—Approximately a 40 percent reduction in overall staffing. Only one company, ServiceMaster, has indicated a sufficient supervisory staff to even attempt to handle this multi complex set of buildings and decentralized mode of operation. Believe that ServiceMaster phasing down of current staffing in four months is overly optimistic and could cause union problems. It would have to be forced attrition and there hasn't been that many jobs open in the AFSCME group. I don't know of any department within the University that isn't trying to reduce costs and the major cost is people. Believe that AMS and Crothall's approval to use natural attrition is the most feasible. It may cost more for the first year of a housekeeping contract. In regards to the number of custodians, I believe that all three companies are overly optimistic with a proposed cut of 40 percent. First of all, none of the companies have indicated any kind of a pool for absenteeism or open positions. No, it may not be needed for the phasing down of staff, but will we have a problem in one year? We just may. This area of Michigan is highly unionized and Ford, Chrysler and GM have not whipped this problem and they have been working on it for years. However, both AMS and Crothall have guaranteed that they can do the job. ServiceMaster has an open-end contract, so again we are comparing applies and oranges.

EXHIBIT 2

AFSCME LOCAL TO CONSULT WITH UNION LEADERSHIP

(By Sue Warner)

Officials of the American Federation of State, County and Municipal Employes (AFSCME, Local 1583), will meet with national AFSCME officials in Washington, D.C., today to discuss the University's subcontracting of housekeeping personnel.

Local 1583 President Dwight Newman, Bargaining Chairman Art Anderson and Secretary-Treasurer Tim Seguin will seek the national office's advice on how to deal with the labor issue which is currently embroiling the University Hospital.

Last Friday, Anderson said the union was "at war with the University" over subcontracting of what AFSCME calls "middle-management" employes at the hospital.

According to University Chief Negotiator William Neff, officials are considering four companies for the hospital housekeeping contract. Many cities and institutions are turning to sub-contracting for greater efficiency in work production, Neff said.

"These companies have handled other hospitals," Neff said yesterday. "We're aiming for over all efficiency—it's not just the company people (we want), but their equipment and materials as well."

However, Newman said, AFSCME objects to the sub-contracting because the union has not been allowed a voice in deciding which company will be hired.

AFSCME officials were not allowed to appear before a hospital executive board meeting dealing with the proposed sub-contracting.

Newman contends the University has already decided to sign a contract with Servicemaster, Inc., an Illinois hospital management firm. The company presently has contracts at Mt. Siani, Mt. Carmel and other Detroit area hospitals.

Neff, however, denied that a contract with Servicemaster had been signed.

"I know for a fact that no contract has been let. Four companies are getting serious consideration and Servicemaster is one," he said.

A union leaflet which appeared in the hospital yesterday urged union members to "keep in mind that the University is owned by the state and people of Michigan. Why does the administration want to contract an out-of-state contractor?"

Newman said he is concerned about a possible loss of union jobs if Servicemaster is contracted.

According to Newman, the company estimates it will be able to reduce the number of AFSCME hospital employees from 278.5 to 204 in two years. Newman

added that the number of supervisory personnel would fall from 28.5 to 26.5 and part of the 26.5 will be Servicemaster employes.

Neff said the employe reduction figures are only "the best estimates as to what the company thinks they can do." The University would avoid lay-offs, reducing staff through attrition, transfer or promotions, he added.

In additon, Neff said the union has no authority to interfere with the hiring of supervisory personnel.

"Supervisory people are not covered by our union contract." Neff stated. "Management has the basic function of determining the size and function of the work force."

Meanwhile, union officials have filed grievance and unfair labor practice (ULP) charges against the University stemming from hospital management's removal of AFSCME leaflets from union billboards last week.

EXHIBIT 2 9/27/77

AFSCME LOCAL 1583

SOMETHING TO THINK ABOUT

President Dwight Newman and Bargaining Chairman Art Anderson met last week with University officials to discuss the pros and cons of the University's decision to sub-contract middle-management to an outside company which we feel has been narrowed down to Service-Master. The purpose of these meetings was to find out the effects the sub-contracting will have on our total membership and the U of M Hospital as a whole. Let's take a look at what will happen according to the information that has been brought to our attention.

A) Service-Master forecasts a savings of about $500,000 for a two year contract which they base on the University's proposed 1977/78 budget. Bear in mind that the University has at this time a total of 270.5 AFSCME unit employees and a total of 28.5 supervisors and management personnel in the Medical Center Housekeeping Department. The 1977 budget calls for 307 AFSCME unit employees and 28.5 supervisors. In 1978 the University's proposed budget will be 335.5 AFSCME unit employees and 28.5 supervisors.

For a two year period Service-Master calls for an increase of 57 employees to service the cleaning of the hospital. However, Service-Master's proposal for a two year contract is to actually reduce the manpower down to 204 AFSCME unit employees and 28.5 supervisors, which is a great reduction in personnel.

The AFSCME unit will lose 78.5 employees and supervisors 1.5. Based on our information, instead of Service-Master bidding on the figure of 270.5 employees in the AFSCME unit and 28.5 supervisors, their bid covers 1977/78 figures of 307 and 335.5 which they have no intention of meeting. This will lower the AFSCME unit in Hospital Housekeeping down to 204 employees and all of this by their contending is to result in a cleaner hospital. Who's fooling who?????????

B) Service-Master is receiving a fee of 4.1% of total labor and products they sell to the hospital. In addition, they make a profit on all their products sold to hospitals. There is no penalty for Service-Master if they do not show a savings--as proposed only an additional profit for them.

C) Service-Master will eventually replace all hospital housekeeping equipment with their own equipment. After a few months, they will also replace housekeeping supervisors with their own people, or at least a large number of supervisors will be replaced. You can see there will never be an opportunity for the hospital to return to in-house housekeeping because of the large out lay for capital equipment and because of the expense involved for supervisors to [illegible] an in-house program. It is very clear that Service-Master will be in the driver's seat.

We all should keep in mind that the University is owned by the state and the people of Michigan. Why does administration want to turn over all this responsibility to an out of state contractor? The State of Michigan is spending a lot of money to improve unemployment and reduce welfare rolls. Why then is the University implementing a plan where an outsider wants to reduce employment by at least 40%? Think about it!!!!!

University of Michigan Employees Local 1583, AFSCME, AFL-CIO, 2956 St. Aubin Ct., Ann Arbor, MI 48104. 971-2951. 9/27/77.

EXHIBIT 3

EXHIBIT "C"

UNIVERSITY OF MICHIGAN HOSPITAL

ANN ARBOR, MICHIGAN

Description of Categories to Which
Pro Forma Expenses are Distributed

I. Hospital Wages

Wages of University Hospital Housekeeping Employees paid directly by Hospital as defined in Agreement.

II. ServiceMaster Direct Expenses

Direct, In-Hospital Expenses incurred by ServiceMaster for the direct benefit of the University Hospitals:

- Salaries of Master Coordinating Manager, Resident Managers and Assistant Managers
- Cleaning Supplies and Minor Equipment
- Use Charges for Major Equipment
- All Project Personnel Salaries
- Supervisors' Salaries, on ServiceMaster Payroll
- Payroll Taxes – Wage Surcharge for Managers and Supervisors on ServiceMaster Payroll
- Unemployment Taxes for Managers and Supervisors
- On Site Staff Expenses, Parking & Management Conferences
- F.I.C.A. for Managers and Supervisors on ServiceMaster Payroll
- Blue Cross-Blue Shield Coverage for Managers and Supervisors on ServiceMaster Payroll
- Relocation Expenses for Managers

III. ServiceMaster Indirect Expenses

Indirect Expenses incurred by ServiceMaster for the direct benefit of the University Hospitals. (4.1% of the total of Categories I and II):

- Regional Manager Salary and Payroll Expense
- Regional Manager on Site Staff Expenses, Parking, travel & Management Conferences
- Employee Training Program Development
- Educational Program
- Area and Divisional Supporting Management Expense
- Project Engineering
- Technical Development
- Auditing of All Quality and Financial Controls
- Program Development for Department Employees
- Clerical Support (area and divisional)
- Insurance
- Employee Benefit Program
- Relocation Expenses for Regional Manager
- Division & Corporate Administration Legal Counsel
- Division & Corporate Plant and Facilities Overhead

IV. ServiceMaster Management Allocation

Other ServiceMaster Corporate Expenses and Contribution (3.2% of the total of Categories I, II, III):

- Contribution to Corporate Profit
- State, Federal and other taxes

EXHIBIT 4

It is important that we realize what an impact can be made during the first few weeks that ServiceMaster serves a new hospital. It is this first impression, the first few words said, the first few smiles, the first few accomplishments, and sometimes the words not said or the things that are not accomplished, that set the pace and climate under which ServiceMaster must operate in the future at any given hospital. There is never a second chance to make a good first impression.

During the past few years we have started many hospitals and from these new responsibilities and opportunities we have gained a wealth of knowledge that can benefit everyone involved in this "cutting edge" of our business.

While each new hospital is different in itself, there are certain tracks or objectives which need to be followed in every case.

We have learned that if there is any one thing that is most important in a start-up, it is in the area of communications. Communication with administration, key hospital personnel, and with the housekeeping supervisors and personnel. All initial changes and the reasons for these changes must be communicated not only to the housekeeping personnel, but also the hospital's administration. This gives the start-up team an opportunity to continually keep the hospital aware of the benefits of the ServiceMaster program. The hospital administration must be supported in its decision by selling positively what ServiceMaster is doing for the hospital.

* It is also necessary that all possible trouble spots are communicated positively to administration and the Personnel Dept. (where applicable) e.g. There might be an employee or a supervisor that the ServiceMaster team senses

a future problem with. This should be communicated to the hospital administration and the Personnel Director. They should never be surprised by a complaining employee. Other trouble spots could be certain nurses or other hospital employees who for some reason resist some change the ServiceMaster program initiated. It is important that the ServiceMaster team is sensitive to these trouble spots and covers them with the administration before our program is damaged. An example of this would be an Operating Room Supervisor resisting the departure of day shift housekeeping personnel.

Of no less importance are the relationships which the new coordinator builds with key hospital personnel in these early days. The key to building these relationships is the responsiveness of the coordinator and the rest of the start-up team. When there is a call or request received it is taken care of immediately and thoroughly. These requests must be handled personally by the coordinator during these early days.

Another area that is key to a successful start-up is the floor program. It is absolutely essential that certain key areas that are viewed by everyone be refinished immediately. This must be followed up by a systematic program. Once the floors are brought up to our standard, they must not slip back to their original state. In most cases, after a few floors are done there will be many requests coming in to have certain other floors done immediately. It is well that these requests are handled as quickly as possible, but it is sometimes necessary to communicate with the department heads and the hospital administration the difficulty of doing all of them at once.

On any new start-up, the Engineering Manager and the new coordinator should have a thorough understanding of the new hospital agreement and the survey file. It is the responsibility of the ServiceMaster representative who sold the new

EXHIBIT 5

ALBERT EINSTEIN MEDICAL CENTER
Northern Division

GENERAL SERVICES STUDY

INTRODUCTION AND SCOPE

The General Services Study was initiated at the request of the Acting Associate General Director for Operations, Mr. Vincent P. Mule', P.E., to review and compare the proposals for Housekeeping Services submitted by the following three firms;

- American Management Services, Division of American Hospital Supply Corporation, formerly known as Red Top.
- Crothall Hospital Services Inc. (current supplier of Housekeeping Services at Albert Einstein Medical Center, Northern Division).
- Servicemaster Industries, Inc.

These three proposals were reviewed and compared for the types and quantity of services to be supplied along with their respective costs, and then compared to performing the housekeeping function using in-house graded and supervisory personnel.

The Albert Einstein Medical Center, Northern Division, originally in 1972, converted from a complete in-house General Services program to an externally managed service, Crothall Hospital Services Inc., which the hospital has maintained for five years. This evaluation is a result of the current dissatisfaction with the apparent lack of cleaniness which is evident throughout the majority of the hospital. This dissatisfaction has been expressed by many department heads, and members of the Executive Management Committee.

EXHIBIT 5

II. SUMMARY:

The Albert Einstein Medical Center, Northern Division, for the past five years has contracted with Crothall Hospital Services Inc. to manage the General Services Department, and to provide all supplies and equipment required to perform the housekeeping functions.

Consideration is currently being given to alternative methods which would provide improved housekeeping service. Three housekeeping service firms have submitted bids to manage the Northern Division General Services Department, to provide acceptable housekeeping services in the required area as identified in Exhibit A. Consideration is also being given to managing the General Services Department internally.

Three vendors who have submitted bids for the housekeeping services are as follows:

Firm		Annual Cost
American Management Services	-	$1,235,702
Crothall Hospital Services Inc.	-	$1,268,654
Servicemaster Industries Inc.	-	$1,238,914

These three bids are based on an average hourly rate for supervised employees of $4.05 per hour, a holiday rate of 9 days per year, and do not include benefits normally provided to hospital employees. Any changes in either the average hourly rate, or holiday allowance, will affect contractual cost. In the case of the Crothall contract, any increases will additionally increase the contribution to overhead and profit, which by contract

EXHIBIT 5

is tied to 6.5% of the total direct cost of the service. The current extrapolated housekeeping cost for the current year (re FY77) is approximately $1,371,000.[1] The lowest of the three bids has the potential of decreasing this hospital's current cost by an approximate $19,000 annually. The changes that have been recommended by these three firms, if implemented, should significantly improve the general overall cleanliness of this institution. The in-house managerial concept would also reduce the current annual expenditures by approximately $100,000, and therefore would allow for a combination of cost containment, and increased emphasis in the overall cleanliness of the institution. Additionally, the in-house alternative allows for increased flexibility to provide other required services as the demands of the hospital change. This flexibility is not readily available with contract services. These services specify areas to be cleaned, methods to be used, and costs associated, and any changes can require charges and possibly contract negotiations.

According to a survey of thirty-six hospital departments, it was indicated, that if all the provisions in the current housekeeping contract were effectively enforced, that they would find the service in most cases acceptable.

The Korman Research building is currently excluded for the Crothall Hospital Services Inc. Contract, and is being maintained by Technical Building Maintenance Inc., at an annual cost of approximately $44,000. This provides for only the basic cleaning of corridors, offices and laboratories. It is estimated that if the houskeeping function were combined with an in-house function for the entire institution, that the cost for cleaning the Korman Research Laboratories would be approximately $22,500, an annual savings of $21,000.

1 - Northern Division Fiscal Office.

EXHIBIT 5

III. RECOMMENDATIONS

The following recommendations are designed to improve the existing overall quality of housekeeping throughout Albert Einstein Medical Center Northern Division while containing costs.

- Employ a complete In-house General Services Management Team.
- Develop procedures and frequencies for cleaning for the entire hospital on an area by area basis. Copies of this procedure should be distributed to the respective department heads.
- Establish a level of cleanliness which is appropriate for the AEMC, Northern Division, and agreed upon by both Administration and the Director of General Services.
- Develop standard times for the cleaning of all areas of the AEMC, Northern Division, so that staffing requirements can be prepared which reflect in established agreed upon levels of cleanliness.
- Inventory, evaluate and appraise all miscellaneous minor equipment currently owned by Crothall Hospital Services Inc., and used at the AEMC, Northern Division, and consider purchasing the minor equipment in an effort to reduce the initial start-up costs.
- Select and order required equipment for the General Services Dept. This equipment when received, should be stored in a secure area, prior to the termination of the existing contract.
- Select and order required supplies and store in a secure area, prior to the termination of the existing contract.
- Develop a supply re-ordering system to eliminate the possibility of shortages or excessive inventory.

EXHIBIT 5

- Develop and implement a Comprehensive Quality Assurance Program based upon a defined standard of cleanliness for the entire hospital.
- Develop a training program for the General Services Dept. to include all employees.

IV. DISCUSSION

The General Services Dept. presently reports to the Associate General Director for Operations, and is currently managed by Crothall Hospital Services Inc. This firm provides the Albert Einstein Medical Center, Northern Division, with the following managerial staff:

1 Field Service Department Director
1 Secretary
1 Assistant Director
3 Day Supervisors
1 Night Supervisor
1 Assistant Night Supervisor

Additionally, Crothall Hospital Services, Inc., provides all equipment and supplies used in the cleaning process, and is responsible for maintaining and cleaning all of their equipment. The managerial support includes group purchasing, training of employees, specialized legal advice, employment screening, specialized labor relations, and quality control programs. The current contract, which is the most recent in a series of one year agreements, beginning in 1972, is scheduled to expire on October 1, 1977. Crothall has been notified of the hospital's intent to cancel this contract. During the life of the Crothall contract, the hospital-employed staff, has been systematically reduced from the original level of approximately 160 full time equivalent (F.T.E.) employees to the current level of approximately 115 F.T.E.

EXHIBIT 5

A survey of 36 of the major departments was performed in an effort to determine their housekeeping needs. Thirty-three of the departments responded, and the consensus of their replies, indicated that in their opinion that very few changes are needed in the current contract to adequately clean their areas. The majority of the department supervisors also indicated that they had not previously seen the current contract, and were not aware of what services were included. The department supervisors also indicated that in most cases if the cleaning specifications in the current contract were strictly followed, that the cleanliness of their areas would be significantly improved, (Exhibit B). The survey required that each department questioned, develop a subjective opinion of the cleanliness of their respective areas. This subjective opinion is a result of the lack of implemented institutional guidelines stating the level of acceptable cleanliness.

The Quality Assurance Program of the Crothall's operation effects the first line management, and is ineffective. This quality control monitoring is reviewed by the General Services Supervisor, signed by the Head Nurse, and Unit Manager for that area, and is then stored in the General Services files. This Quality Control Program does not provide for a statistical base in order to measure the overall quality of housekeeping services, and is not distributed to Administration. A system that has been proven to be effective in other Health Care Institutions is one where an Administrative Representative, and the Director of Housekeeping make regular tours of the institution, randomly selecting certain specific areas, and critically evaluating those areas for cleanliness. This type of program encourages active communications between Administration and the Director of General Services (i.e. The General Services Department). This communication enables the Housekeeping Department to understand, on a regular basis, the areas that other individuals believe need additional cleaning. The Quality Assurance Survey Form, (Exhibit C), could

be used for a survey of this type, and would allow for the statistical plotting of quality level. This level of quality should also be compared to the current General Services staffing patterns, so that quality could be equated with hours worked in the department. All three of the vendors that were selected to submit bids for the Housekeeping Service claim to have an overall Quality Control Program as already described. Unfortunately, this type of comprehensive program covering the total hospital, and being distributed to Administration, has not been implemented at the Albert Einstein Medical Center, Northern Division.

The three vendors, American Management Services, Inc., Crothall Hospital Services, Inc., and Servicemaster Industries Inc., were selected and invited to submit bids for the Housekeeping Services required at Northern Division. These bids were to include all buildings on the Northern Division Campus, excluding the Korman Research Building, the Moss Rehabilitation Building, and the Willowcrest-Bamberger Extended Care Facility. Several other isolated areas, such as the Maintenance Workshops, Mechanical Rooms, Boiler Rooms, Dietary, Operating Room, etc. were also excluded. Generally, as is indicated in Exhibit D, the three firms provide similar services, utilizing individual methods which each believes is most effective. The major differences in services provided are in the area of cleaning specific items such as Delivery Room Suction Bottles, and concepts concerning cycle cleaning. These different concepts have resulted in a significant difference in the staff requirements, with American Management Services recommending 95 F.T.E. employees; Crothall Hospital Services recommending 113 F.T.E. employees, and a five (5) man cycle cleaning team; and Servicemaster Industries recommending 113 F.T.E. employees. The resulting contractual costs for one year's service are: American Management Services $1,235,702.00 for the first year; Crothall Hospital Services, Inc. $1,268,654.00; and Servicemaster Industries Inc., $1,238,914.00. These costs compared to the current anticipated contractual cost for fiscal year 1977, of

$1,244,027.00, indicates that American Management Services, and Servicemaster Industries would both be nominally less expensive, but would require that Northern Division find alternative methods of cleaning movable equipment in the Delivery Rooms, and Nurseries.

A comparison of In-House versus Vendor-Managed Housekeeping at Northern Division is as follows. Currently, Crothall Hospital Services Inc. provides managerial expertise, which consists of (1) Director of General Services, 1 Secretary, 1 Assistant Director, 3 Day Supervisors, 1 Evening Supervisor, and 1 Evening Assistant Supervisor. Additionally, 2 Day Supervisors are employed by the Albert Einstein Medical Center, supplementing the existing managerial staff. An in-house function would require that a managerial staff, as previously mentioned, would have to be employed, as indicated on the Organization Chart, Exhibit E. It is estimated in Exhibit F, based on the current wage rates for the Delaware Valley, and the Northern Division, that the In-House Managerial Team would cost, including fringe benefits, $160,529.00 for the first year. Additionally, new equipment would be needed to replace the equipment that is currently provided by Crothall Hospital Services. The initial start up costs include $37,470 for purchased equipment (Exhibit G); $2235.00 a one-time expense for the purchase of minor equipment currently owned by Crothall; and $6012.00 for the initial two months of supplies (Exhibit N) totaling $45,717.00 Additional first year costs of $3747.00 for depreciation of major equipment, and $33,066.00 for supplies are required, and are included in the total cost calculation for in-house cleaning. The total anticipated cost for the in-house function for the first year, including supervisors, based on a $4.05 average hourly rate for the existing supervised employees, would be $1,138,794.00, a net reduction of approximately $100,000 to the current anticipated cost for fiscal year 1977.

Staffing requirements for the General Services should be developed based on micro analyses of the tasks and frequencies that are required for each area.

EXHIBIT 5

This is most accurately and efficiently accomplished through the use of pre-determined standards, adjusted, where necessary, to the institution where they are being installed. These standards when compiled, will enable the new Director of General Services to accurately determine the number of F.T.E. employees that are required to staff that department.

Some of the departments surveyed indicated that additional housekeeping services were needed, that were not covered in the current contract, and these were not covered in the three bid proposals. These services are:

- Cleaning of the Dietary Offices, Main Kitchen, ground floor Hackenburg building.
- Surgical cleaning of the Cardiac Catheterization Laboratory, ground floor Hackenburg Building.
- Increased frequency in cleaning of carpets in the Admission Department, 1st floor Hackenburg.
- Vacuuming of sub-floor area in Computer Room quarterly.
- Reducing the frequency of spray buffing in the Gift Shop from daily to three times per week.
- Increasing the frequency for emptying of patient trash baskets.
- Implementation of Specification B in the Pharmacy area.

EXHIBIT 5

ALBERT EINSTEIN MEDICAL CENTER
Northern Division

Cost Comparison

	Current Cost FY1977	Inhouse	A.M.S.	Crothall	Servicemast
Management Salaries	N/A	$160,529 (1)	N/A	$139,010	N/A
Equipment	N/A	5,982 (2)	N/A	38,840 (3)	N/A
Supplies	N/A	39,074 (4)	N/A		N/A
Graded Employees	$974,720 (5)	$930,209 (7)	$800,280 (9)	$955,120 (10)	$951,912 (
Graded Employee Benefits	$126,714 (6)	$134,880 (8)	$116,041 (8)	$138,492 (8)	$138,027 (
Cycle Cleaning Team	-		-	$ 56,790	-
Contribution to Overhead & Profit	N/A	- 0 -	N/A	$ 77,334 (12)	N/A
Contractor's Tax ty of Philadelphia	$1,250	- 0 -	$2,177	$1,560	$1,435
Total Contractor's Fee	$249,907	- 0 -	$435,422	$313,534 (13)	$287,002
Total Annual Cost	$1,371,341	$1,270,674	$1,351,743	$1,407,146	$1,376,941
Net Changeover Current year		- $100,667	- $19,598	+ $35,805	- $5,600

FOOTNOTES:

1. Management salaries and benefits, Exhibit F.
2. Total major equipment cost amortized over 10 years as recommended by AHA plus minor equipme Exhibit G.
3. Combined cost for supplies and equipment.
4. Supplies for 1st year including required inventory.
5. Obtained from FY1977 extrapolation on FY78 budget worksheet.
6. Benefits based on current rate of 13%.
7. Based on an average rate of $4.05/hour and 113 FTE employees minus 2 supervisors.
8. Benefits based on projected rate of 14.5% as recommended by the Fiscal Office.
9. Based on 95 F.T.E. employees @$4.05 average hourly rate.
10. Based on a total of 235,832 paid hours @$4.05 average hourly rate.
11. Based on a total of 113 FTE employees @ $4.05 average hourly rate.
12. Based on a rate of 6.5% of the Total General Services annual cost.
13. Contractor's fees include management salaries, equipment and supplies, cycle cleaning, contribution to overhead and profit, and contractor's tax.

FJR/bb

EXHIBIT 6

Contract housekeeping: hospital survey cites reasons for termination

BY JOSEPH D. BROWN, Ph.D.

HOUSEKEEPING

Based on a survey of a small group of hospitals, this article attempts to discover the reasons why hospitals have discontinued their contracts with outside firms in an effort to help hospital administrators avoid the pitfalls that can be associated with contracting for housekeeping services

Editor's Note

Turning over the day-to-day management of certain hospital departmental functions to an outside contractor is an alternative that has been available to hospitals for many years. If he thinks that it makes good management sense, today's administrator can negotiate agreements with contractors to provide services ranging from food to pharmacy to physical therapy.

Housekeeping was one of the first hospital services that outside contractors offered to provide, and the success of most such arrangements may be reflected in the large number of hospitals that currently delegate this service to others. According to the most recent (1975) American Hospital Association figures, no less than 11.9 percent of the nation's hospitals have come to accept contract housekeeping as a way of management life.

But contract housekeeping has not worked in all hospitals that have tried it—probably for as many reasons as there are variables within hospital and contractor organizations and in relationships between the two. The article that follows is based on a study that attempted to discover why a small group of hospitals that decided to try contracting for housekeeping services eventually discontinued the arrangement. It is presented for the purpose of helping hospital administrators who are considering such services to avoid the possible pitfalls that lurk in imprecise comparative costing, inadequate performance safeguards, and insufficient controls. The reader should not infer that these experiences are in any way generally representative of results that might be expected with hospital contractors for housekeeping or any other hospital service.

The purpose of the survey that is described in this article was to determine why hospitals initially hired contract management firms for housekeeping services and why they later dismissed them.

A list was obtained of 74 hospitals that had hired and subsequently fired contract companies in recent years. These hospitals were dispersed throughout the United States and they varied in bed size from under 100 to more than 500, with more than half of the hospitals in the 100- to 249-bed range; nearly a third in the 250- to 499-bed range.

The study began in July 1980 with a letter to the administrator of each listed hospital. The letter explained the purpose of the survey and that the administrator or other individual who was responsible for hiring and terminating a maintenance firm would be telephoned to discuss the nature of their negative experience with contract housekeeping.

Of the original 74 administrators who were contacted, 12 were not interested in participating, 24 could not be reached, and 38 respondents were ready, willing, and able to take part. The findings reported here are based on, and are subject to the limitations of, this admittedly small sample.

THE QUESTIONNAIRE

The first section of the questionnaire that was used for the telephone interviews asked why the outside contractor was hired and terminated, and each respondent was asked to explain the particular circumstances of their hospital. The second and final section contained 13 statements about the contract itself, operational factors, and the personnel who were provided by the contractor. Respondents were asked to agree or disagree with each statement and to rate—on a scale of 1 to 10—whether or not the contract company had delivered the services that it had initially promised to provide.

WHY THEY HIRED

The principal reason that was given for hiring a contract company by nearly half of the respondents was the inability of hospitals to find and to retain a good executive housekeeper. Secondary reasons for hiring an outside firm included expected cost savings, better quality housekeeping, and the availability of proven housekeeping methods and expertise. Other reasons that were given by a minority of administrators included their desire for fewer employee problems, the influence of other management people, an end to having to purchase maintenance supplies, expectation of good accountability of services rendered, better trained people, and cuts in administrative time.

A typical comment about hiring a contract firm was: "We listened to their sales story, and we felt a company could bring us a lot of support services that we couldn't afford ourselves. Secondly, we felt they would bring us experience in management that we just didn't have at the time. Third, they seemed to provide a sense of professionalism."

WHY THEY FIRED

The two main reasons given for the termination of contract services were a lack of cost-effectiveness and a lack of accountability. Additional reasons

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included poorer quality housekeeping, a lack of housekeeping control, the hiring by the hospital of a qualified supervisor, too much management turnover on the part of the contractor, failure to cut administrative time/supervision, and conflicts with the contractor's assigned executive housekeeper.

Administrators' comments about the cost-effectiveness of the contract services included: "It was not cost effective. The actual cleaning job was one of the key things. It just wasn't being done." And, "We felt that by eliminating the contractor we could decrease our costs by cutting out their management fee."

One administrator expressed the lack of accountability this way. "The hospital wasn't very clean. We had a lot of trouble and many patients complained. In addition, we didn't receive an effective response from the company when we would notify them of difficulties or problems."

Another respondent mentioned trouble over the contract agreement. "(We had) escalating costs in the contract that began to jump dramatically. We had a construction project going on, and as the contractor began to take over the responsibility of the new square footage, the contract was changed several times. We felt the changes were a little bit more than they were worth."

ADMINISTRATORS' ATTITUDES

Despite the foregoing negative comments, when administrators responded to questions about the contract in the second section of our questionnaire, most of them felt that the agreement itself was easy to understand. However, many respondents, (particularly from small hospitals) said that they were unable to identify specific costs in the contract for supplies, equipment, personnel, and the management fee. A majority of respondents agreed that the contract was easy to renegotiate as the hospital's needs changed.

More than three-quarters of the respondents gave negative answers when asked if the purchasing and infection control departments were free to select housekeeping products, and only half of the hospitals surveyed knew if legal counsel had reviewed the contract before it was signed.

Another administrator said the hospital had thought that certain levels of cleaning had been agreed upon, but when they analyzed the statements in the contract, they did not conform with what had been verbally agreed upon.

OPERATIONAL FACTORS

In terms of operational factors, slightly more than half of the administrators felt that the contract company had met their housekeeping standards. On the other hand, more than half of all of the respondents indicated that other hospital departments were dissatisfied with the contractor's housekeeping services. A much smaller group felt that they had lost control over housekeeping functions. Both the dissatisfaction of other departments and the loss of control were problems more often felt by large hospitals than small ones.

When the respondents were asked if they had realized the savings that were predicted to result from the contract, 16 administrators said they did not save any money by employing an outside firm, 13 felt they had saved, and 9 others did not know.

CONTRACTOR PERSONNEL

When surveyed on their attitudes toward contractor personnel, a majority of hospitals said that as much time was spent administering the housekeeping function after the hiring of a contract firm as had been spent before. The same majority felt that the contractor's housekeeping personnel lived up to expected performance standards. Most of the respondents were satisfied with the firm's housekeeping director; however, more than one-half were dissatisfied with the high turnover rate among contractor-supplied housekeeping directors.

Following is one commentary on personnel problems. "We had some difficulty because of the fact that the housekeeping people did not feel that they were working for the hospital. They felt that they were working for someone else, and they were reluctant to take directions from us. Even though they were our employees, and only supervised by the outside firm, they immediately viewed that firm as being responsible for giving them directions."

In commenting on housekeeping management turnover, one administrator felt that his hospital became a training ground, and that as a result, there was a lack of continuity in the services provided. Another said that if the hospital were to sign with another outside firm, the contract would have to spell out and guarantee the length of time a good manager would remain at the institution. A third said the firm's manager was good, but that the services delivered were of poor quality because hospital budgetary restrictions made it impossible for the manager to hire qualified personnel. Finally, the larger hospitals surveyed were less satisfied with the contractor's director of housekeeping than were smaller institutions.

CLOSING QUESTION

In seeking an overall opinion from the hospital administrators who were involved in the hiring and/or terminating of contract maintenance companies, we asked them to rate the degree to which the contract company had delivered the services that it had promised. On a scale of 1 to 10, the average rating that outside contractors received was 6.3.

In order to understand why some administrators rated the contract companies higher or lower than others, we measured each person's answer to the closing question against the responses they gave to each of the measured opinion areas in the questionnaire. The main reasons cited by respondents for giving companies lower overall performance ratings were the dissatisfaction of other hospital departments with the contractor housekeeping services and the administrator's feelings that the hospital was losing control over the housekeeping department. Other factors that contributed to low performance ratings were the failure to save money as predicted, dissatisfaction with the assigned director of housekeeping, and the feeling that the personnel who were hired by the contract company did not live up to the standards expected by the hospital.

Based on cross measurements of all of the survey respondents, it became clear that operational factors outweighed opinions about the contract itself or the personnel who were hired by the contractor when it came to forming a final judgment of the outside housekeeping company. ■

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EXHIBIT 7

HOSPITALS TRANSFERRING FROM HOUSEKEEPING SERVICES TO IN-HOUSE HOUSEKEEPING

Hospital	Approximate Date
Herrin Hospital Herrin, Illinois	Prior to September, 1977
Silver Cross Hospital Joliet, Illinois	" " " "
St. Mary's Hospital Kankakee, Illinois	" " " "
Hammond-Henry District Hospital Geneseo, Illinois	" " " "
Doctors Hospital Carbondale, Illinois	" " " "
Rockford Memorial Hospital Rockford, Illinois	" " " "
Guernsey Memorial Hospital Cambridge, Ohio	" " " "
Radford Community Hospital Radford, Virginia	" " " "
McDonough District Hospital Macomb, Illinois	" " " "
Medical Cities Dallas, Texas	" " " "
General Rose Memorial Hospital Denver, Colorado	" " " "
Burlington Hospital Burlington, Iowa	" " " "
Muscatine Hospital Muscatine, Iowa	" " " "
St. Joseph Hospital Syracuse, New York	" " " "
Irving Community Hospital Irving, Texas	" " " "
Buffalo General Hospital Buffalo, New York	" " " "
Forkosh Memorial Hospital Chicago, Illinois	" " " "
St. Joseph Hospital Chicago, Illinois	" " " "

EXHIBIT 7

Hospital	Approximate Date
Holy Name of Jesus Hospital Gadsden, Alabama	September, 1977
Emory University Medical Center Atlanta, Georgia	" " "
Southeast Missouri Hospital Cape Girardeau, Missouri	October, 1977
Hillcrest Baptist Hospital Waco, Texas	October, 1977
Presbyterian Hospital San Francisco, California	Late fall, 1977
St. Francis Hospital San Francisco, California	Fall, 1977
Galion Community Hospital Galion, Ohio	December, 1977
St. Agnes Hospital Fond du Lac, Wisconsin	February, 1978
Allef General Hospital Houston, Texas	January, 1978
Albert Einstein Hospital Philadelphia, Pennsylvania	January, 1978
Coweta General Hospital Newnan, Georgia	February, 1978
Allegan General Hospital Allegan, Michigan	February, 1978
Edward H. White Hospital St. Petersburg, FLorida	March, 1978
M. D. Anderson Hospital University of Texas Houston, Texas	February, 1978
Outagamie County Health Center Appleton, Wisconsin	February, 1978
St. Mary's of the Plains Hospital Lubbock, Texas	September, 1977
University of Washington Hospital Seattle, Washington	January, 1977

EXHIBIT 7

Hospital	Approximate Date
Riverview Hospital Crookston, Minnesota	Unknown
St. Agnes Hospital Fresno, California	"
Madera Community Hospital Madera, California	"
Rose Medical Center Denver, Colorado	"
St. John's Hickey Memorial Hospital Anderson, Indiana	March, 1978
Logansport Memorial Hospital Logansport, Indiana	March, 1978
A.I. duPont Institute Wilmington, Delaware	Early 1978
Independence Hospital & Sanitarium Independence, Missouri	May, 1978
Union Hospital Terre Haute, Indiana	May, 1978
Katherine Hamilton Mental Health Ctr. Terre Haute, Indiana	April, 1978
Coatesville Hospital Coatesville, Pennsylvania	August, 1978
Coffee County Hospital Burlington, Kansas	
Flow Memorial Hospital Denton, Texas	September, 1978
Memorial Hospital of Dodge County Fremont, Nebraska	
Christ Hospital Oak Lawn, Illinois	November, 1978
Northampton Accomack Memorial Hospital Nassawadox, Virginia	

EXHIBIT 7

Hospital	Approximate Date
Memorial Hospital Colorado Springs, Colorado	January, 1979
Emanuel Hospital Portland, Oregon	March, 1979
University of North Carolina Memorial Hospital Chapel Hill, North Carolina	June, 1979
Detroit Central Hospital Detroit, Michigan	July, 1979
Peninsula General Hospital Salisbury, Maryland	August, 1979
Mercy Hospital Port Huron, Michigan	
David Brotman Memorial Hospital Culver City, California	August, 1979
Whittier Community Hospital Whittier, California	August, 1979
Hollywood Community Hospital Los Angeles, California	August, 1979
Queen of the Valley Hospital West Covina, California	August, 1979
Sam Houston Hospital Houston, Texas	July, 1979
Memorial City General Hospital Houston, Texas	July, 1979
Moody House Foundation Galveston, Texas	August, 1979
Rosewood General Hospital Houston, Texas	September, 1979
St. Catherine's Hospital Kenosha, Wisconsin	

EXHIBIT 7

Hospital	Approximate Date
University of Pennsylvania Hospital Philadelphia, PA.	December 31, 1979
St. Luke's Hospital Denver, Colorado	December 31, 1979
St. Francis Hospital East Monroe, LA	January, 1980
Tri-County Hospital Springfield, PA	January, 1980
Glenwood Hospital West Monroe, LA	March, 1980
Children's Hospital Denver, Colorado	March, 1980
Cuyahoga Falls General Hospital Cuyahoga Falls, Ohio	February, 1980
Deaconess Hospital Milwaukee, Wisconsin	February, 1980
Grady Memorial Hospital Chickasha, Oklahoma	April, 1980
Southwest Detroit Hospital Detroit, Michigan	March, 1980
Palm Harbor General Hospital Garden Grove, California	May, 1980
Gardena Hospital Gardena, California	May, 1980
Porter Memorial Hospital Valparaiso, Indiana	June, 1980
Emanuel Hospital Portland, Oregon	1979
Union Hospital Terre Haute, Indiana	August, 1980
Oklahoma Osteopathic Hospital Tulsa, Oklahoma	August, 1980
St. Francis Hospital Wilmington, DE	November, 1980
Northridge Hospital Foundation Northridge, CA	September, 1980

EXHIBIT 7

Hospital	Approximate Date
Parkview Community Hospital Riverside, CA	September, 1980
Community Hospital of Sullivan Co. Harris, NY	October, 1980
Aurelia Osborn Fox Hospital Oneonta, NY	October, 1980
Marion Health Center Hospital Sioux City, IA	November, 1980
West Texas Hospital Lubbock, TX	January, 1981
Women's Hospital Houston, TX	January, 1981
Shenango Valley Osteopathic Hospital Farrell, PA	January, 1981
Hocking Valley Hospital Logan, OH	January, 1981
Feather River Hospital Paradise, CA	February, 1981
St. Francis Hospital Medical Center Peoria, IL	February, 1981
Immanuel Medical Center Omaha, NE	March, 1981
George Washington Univ. Medical Ctr. Washington, D.C.	March, 1981
Parkview Episcopal Hospital Pueblo, CO	April, 1981
Methodist Hospital Peoria, IL	April, 1981
Grinnell General Hospital Grinnell, IA	June, 1981
Knoxville Hospital Knoxville, IA	June, 1981
Louise Lisner Home Washington, D. C.	August, 1981
Davis County Hospital Washington, IN	August, 1981
St. Joseph Hospital Patterson, NJ	October, 1981

Mrs Strebel
Housekeeping Officer

DEPARTMENT OF THE NAVY

Memorandum

DATE: 23 September 1975

FROM: Chief, Operating Management Service

TO: Chef, Fiscal Service

SUBJ: Commercial/Industrial Activities Program

Ref: (a) NAVMATINST 4860.12A

Encl: (1) Housekeeping Officers Survey

1. After review of the Housekeeping Program including alternatives, I recommend use of circumstance Code "A" in that a commercial housekeeping contract would disrupt an essential program.

2. The Housekeeping Officer has surveyed a number of hospitals in New England relative to cleaning by commercial contract. Few, if any, are totally satisfied with contract cleaning. While the reasons are many, the pivotal issue revoles around management control and the protection of their investment in housekeeping equipment. Currently, our investment in equipment alone is approximately $12,500. Should we go to contract cleaning this equipment would be lost to us through outright purchase or transfer. If a commercial contract was entered into, and later found unsatisfactory, a major outlay for new equipment would be necessary.

3. The elements of management control and flexability are of great concern. A contract would have to be specific and necessarily entail an outlay for completion of certain items which may not demand attention on a recurring basis enough to justify the cost. On the other hand, failure to include such items in the original contract would lead to expenditures far and above the original estimate. This has been found true in almost all situations. Secondly, the division of labor at the NSHC (Aide I's and Aide II's) would certainly be hampered if all custodial chores were done by contract. This would most assuredly affect the current flexability now enjoyed by management in responding to the needs of both staff and patients.

4. Despite the known impact of budgetary and civilian manpower constraints, the housekeeping staff enjoys a well earned reputation throughout the center. This reputation is built upon mutual trust and confidence inherent in the relationship between employer and employee in the Federal service. Should this relationship be disturbed through adoption of contract services, the reliability factor of this small and dedicated group would be destroyed. Continuity of service based on months of training would be lost. I believe the control factors now available to management, particularly in view of our austere personnel situation, should be the most compelling factor in retention of our own housekeeping force.

E. E. Carroll

E.E. CARROLL

28 August 1975

From: Head Housekeeping Officer
To: Chief Operating Services

Subj: 1st Stage Contract Investigation

Per your request I made contact with local hospitals, and regional hospitals. I also contacted a few hospitals outside New Engaland. Investigated were both Federal Hospitals and Civilian Hospitals

1. Stelpens Memorial Hospital, Norvary Maine. 41 Beds- The director of purchasing investigated both contract and local labor. Decided on the basis of employee control and cost that it was cheaper to use in house cleaning.

2. Braintree Hospital, Braintree Mass. 160 Beds- This hospital is currently under contract cleaning with Red Top. Has been since March. They charge above the stated contract price for heavy cleaning,(special projects) and details that remove an employee from assigned area.

3. Brattleboro Hospital, Brattleboro Vt. 96 Beds- This hospital used to use Servicemaster. Has been inhouse for two years. It has proven to be cheaper even with an expansion of staff. When Servicemaster did a good job they did a good job but when they did a bad job they did a very bad job.

4. University Hospital, Boston Mass. 400 Beds- For eight years Servicemaster was used. A year ago, when faced with escalating costs they decided to go inhouse. Inhouse has built employee morale and identification and productivity has increased. It is cheaper even with the capitol expenditure for uniforms, supplies, and equipment. Servicemaster not only lost the account because of dollar value but also on the basis of nonperformance. While administration had decided that it would be eneless headache to let Servicemaster do the job. It was found that they still had to constantly monitor and deal with performance standards and quality control.

5. Mercy Hospital, Portland Maine. 185 Beds- Until four years ago this was a Servicemaster account. The switch was made on the basis of cost because items that had to be done were extra billing by Servicemaster.

6. Jamestown General Hospital, Jamestown N.Y. 140 Beds- A year ago Servicemaster tried to sell their contract to this hospital. Administration considered their workup and price and decided to stay inhouse because their own housekeeper was satisfactory as a manager and cost would escalate when the contract had to be renewed.

7. Sharon Hospital, Sharon Connecticut. 92 Beds- Has been inhouse since inception. Contract services investigated but unable to perform functions of inhouse at a comparable price.

8. Peter Bent Brigham, Boston Mass. 331 Beds- An interesting situation. Has Servicemaster in and then terminates. Gets another Contractor. Terminates. Back to Servicemaster. Back to a third contractor. And back to Servicemaster. This over a ten year period. Always unsatisfactory performance.

28 August 1975

Now inhouse. Satisfied with performance of housekeeping Dept. at this point.

9. Hahnemann Hospital, Worcester Mass. 240 Beds- Currently under contract to Stroh Associates. Has been for the past 4 years. Little other information available.

10. New England Hospital, Tufts University. This used to be Servicemaster. Much the same reasoning that prompted University Hospital of Boston (see 4) to change to inhouse was the justification used here.

11. L & M Hospital, New London Conn. Has been Servicemaster for the past 6 years. Is used by Servicemaster as an institution to look at. They're proud of having been there 6 years and prospective clients are encouraged to investigate how satisfied L & M is with their program.

12. Winchester Memorial Hospital, Winchester Va. 460 Beds- Contractors judged a year ago. Decision to stay inhouse motivated by cost factor.

13. Backus Hospital, Norwich Conn. Inhouse but contracts to have window cleaning done. Constantly arguing with contractor about need to be able to inspect, dates of performance, and quality. Displeased with service but disinclined to stop. I couldn't dig out why.

14. Rhode Island Hospital, Providence R.I. Contractors have been investigated. Their quality of work and performance, plus cost would not equal what the hospital is getting for their money now.

15. Emerson Hospital, Concord Mass. 234 Beds- Used to be Servicemaster. Inhouse for two years. Administration found that Servicemaster management left something to be desired. As part of the sales presentation Administration was promised that not only would they have a trained manager but they would also have a trainee manager. When the trained manager left, often very quickly, the hospital was left with a trainee with little knowledge. Administration also found themselves with new managers because as a trainee improves he or she gets promoted to another institution. Lack of continuity. It was also found that because Servicemaster was supplying material, at a charge basis, that there was some abuse. Inhouse cleaning had to strip 10-16 coasts of sealer from the decks when the switch was made. This means shiny floors but poor housekeeping technique. And Servicemaster was used once before by this hospital. They vow never again. They also feel they're saving money in the long run.

16. Ireland Army Hospital, Fort Knox Ky. 500 Beds- This hospital functions under a dual system. A combination of contract and civilian employees. The housekeeper, a GS, finds it easier to discipline the contract employees but for special projects or odd jobs uses the GS's because it saves his budget. Runs transportation and phones, and uses Military Personnel.

17. U.S. ARMY Hospital, Fort Campbell Ky. 240 Beds- The same set up as #16 with the same results.

28 August 1975

18. Letterman Army Hospital, San Francisco Calif. Has fired two different contractors for nonperformance. Still in litigation with one. Currently using another servite and WG's. GS operates same as 16 and 17 with same reasoning.

19. Oakland Naval Hospital, Oakland Calif. Was contracted out. Went inhouse on cost and nonperformance by contractor.

20. VA Hospitals. All VA Hospitals run inhouse because of cost factors.

GENERAL IMPRESSION: Contracting out means losing control. The nonperformance means that the contractor apparently does not meet his own contract or the expectations that administration originally had when signed up. Hospitals found it extra expensive to have to purchase supplies from the contractor. Also extra expensive to have to pay a charge because a broken bottle or vomit had to be cleaned up. If a rapport was reached with the contract manager and things were running well, they found that they lost the manager. The contractor moves the managers around both as troubleshooters and to promote. The manager isn't interested in the institution except as a stepping stone within the career ladder of the company. Contractors have been found to bill for services that were never performed and supplies never used. Also, while quality control and programmed work schedules are featured in the sales presentation, the hospital often finds it difficult to monitor. Removal of trash has sometimes been left out of contracts thus leading to extra billing. And contract prices slide upwards at renegotition no matter which way the contract originally was negotiated.

While I didn't obtain any figures the responses I got that said they were saving money surprised me. I had thought employee morale and hospital identification would be used as answers but cost seemed to be the major factor along with control.

Respectfully submitted,

L. F. Strekel

L. F. STREKEL

How to get a breakdown on your housekeeping contract when your maintenance company won't break down and tell you.

Usually, hospital contract maintenance companies avoid rendering an itemized breakdown of their services. Instead they prefer to issue lump sum statements.

But there is a reliable way for you to determine what you are getting for your money. Here's how:

Take the number of Full Time Equivalent hours (FTE's). Multiply by the Average hourly Wage (AW). Then multiply again by the Yearly Hours (YH). Subtract the Total Contract Cost (TCC), and you're left with the Management Company Gross Profit (MCGP). If you are on a contract under which chemicals are supplied, subtract $45-$55 per bed. (Hand soap, paper and liners are excluded.)

Subtract an additional amount for what most companies pay their Executive Housekeepers and you've figured out their net fee.

In the case of a 63-bed hospital (see box), the management firm was paid over $38,000 to supply *one* Executive Housekeeper the hospital didn't even have control over.

Even if the contract maintenance proposal passes the "breakdown" test, there are other questions you should ask...

What work will be performed? By whom? On a clearly specified basis or "as needed?"

Will you lose control over information...performance...and answerability? Who'll own your equipment?

Finally, by *eliminating the contractor's fee, can't you perform the same work more economically in-house?*

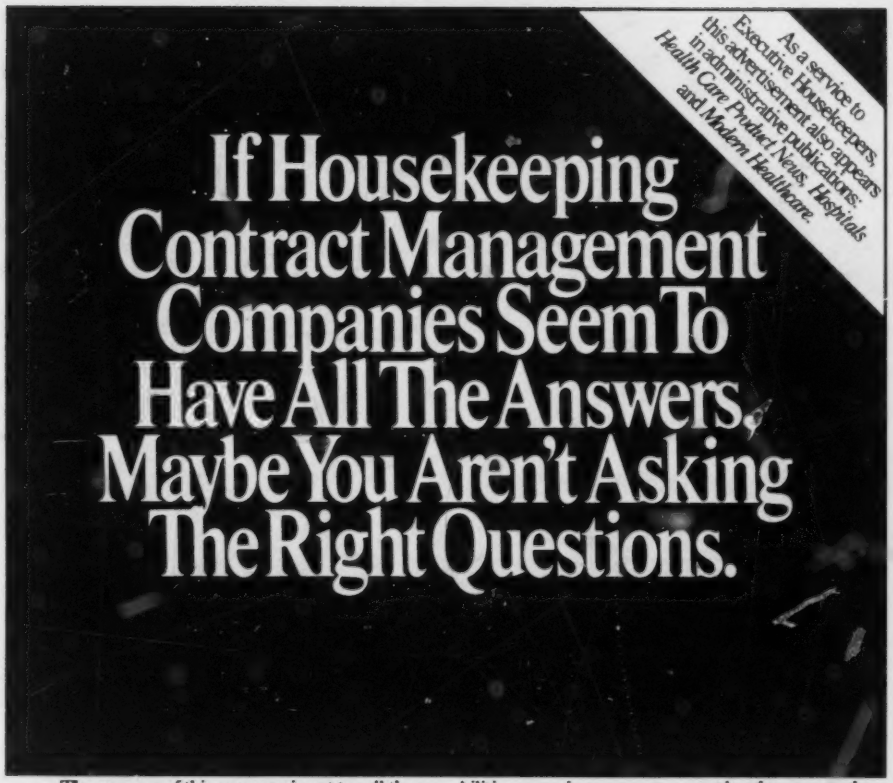
For a fuller discussion of these and other contract management related questions, contact Gary Mullennix, President, Huntington Laboratories, Inc., P.O. Box 710, Huntington, Indiana 46750. (219) 356-8100.

FTE × AW × YH − TCC = MCGP

Full Time Equivalent hours × Average Wage × Yearly hours − Total Contract Cost = Management Company Gross Profit.

At a 63-bed hospital the dollars and cents worked out like this:

FTE's	10.3
Average Wage (with benefits)	$4.24
Yearly Hours	2,080
Total Wages	$ 90,836.00
Total Contract Cost	$129,818.00
Management Company Gross Profit	$ 38,980.00
Less Chemical Supplies (fill in)	$ _____
Less Executive Housekeeper's Wage (fill in)	$ _____
Management Company Fee (Net)	$ _____


As a service to Executive Housekeepers, this advertisement also appears in administrative publications: Health Care Product News, Hospitals and Modern Healthcare.
If Housekeeping Contract Management Companies Seem To Have All The Answers, Maybe You Aren't Asking The Right Questions.

The purpose of this message is not to sell the products or the reputation of Huntington Laboratories. It is to raise specific questions we think will be of value in appraising the merits of contract management proposals.

The contractor proposes to deliver the same housekeeping services you're receiving in-house. The question is, do you know, in detail, what services your housekeeping staff performs—including those which don't appear on organizational charts and job descriptions?

The contractor proposes to save you money. The question is, how much money will be saved by transferring work to other departments? And how much regularly-performed work will be done on a loosely-defined "as needed" basis?

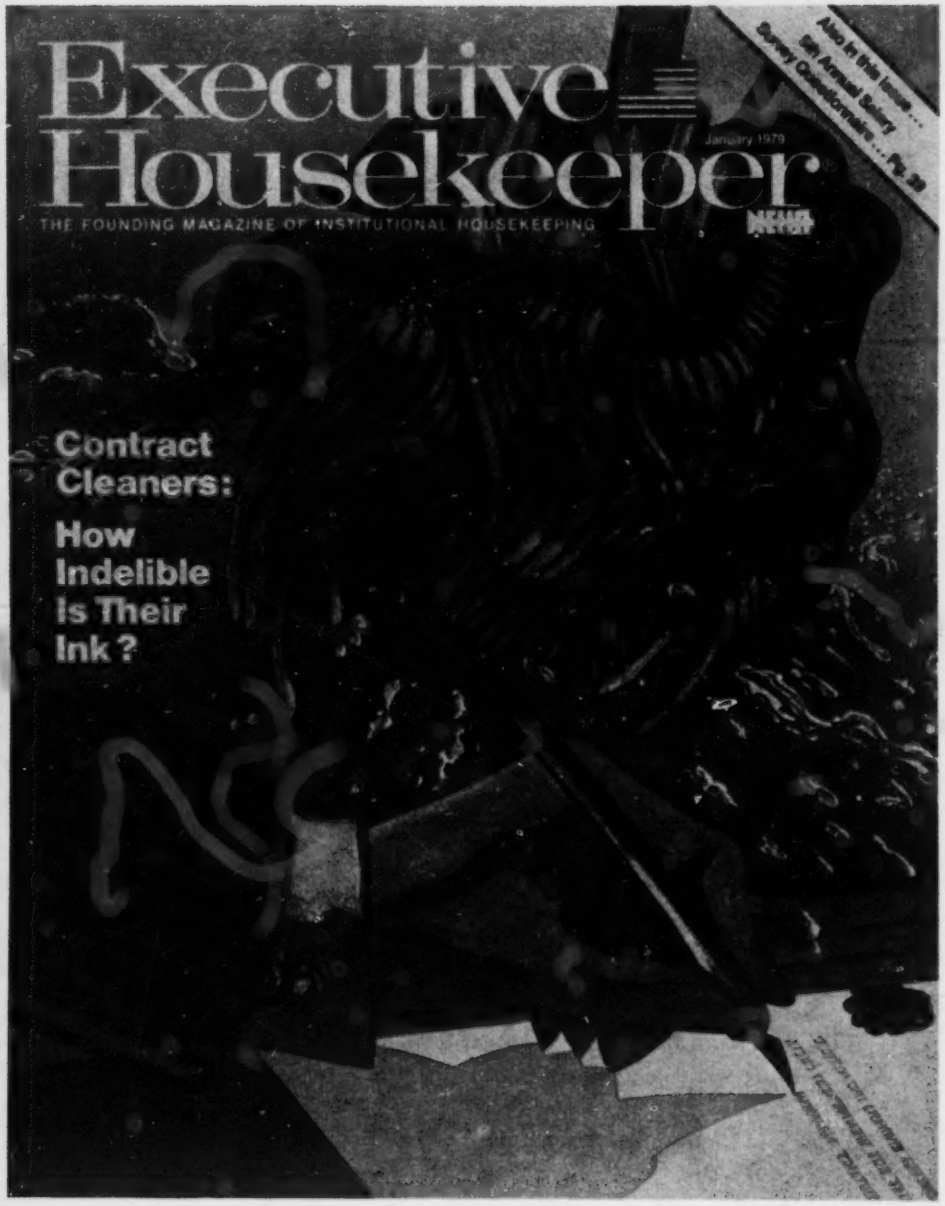
The contractor proposes to relieve you of work. The question is, to what degree will this relieve you of control—over information, performance, answerability?

The contractor proposes to relieve you of headaches. The question is, why doesn't the contract relieve you of employee-relations and union responsibilities—surely among your most burdensome and time-consuming?

The contractor proposes, finally, that only his approach can accomplish these unquestionably worthwhile goals. The question is, can an outside manager actually do anything you and your managers can't? Furthermore, by eliminating the contractor's fees, can't you do it even *more* economically?

Despite our questions, however, we at Huntington do not believe that all contract management arrangements are inferior to in-house operations, particularly if the contract is easy to terminate and has the approval of your attorneys. We simply believe that the only way you will ever have a contract you can live with—or a Housekeeping Department you can be proud of—is to know precisely what you've got, exactly what's being proposed, and, ultimately, how much your decision will cost. In money and in service.

For a fuller discussion of the in-house versus contract management question, contact Mr. Gary Mullennix, President, Huntington Laboratories, Inc., P.O. Box 710, Huntington, Indiana 46750, (219) 356-8100.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January 1979
THE FOUNDING MAGAZINE OF INSTITUTIONAL HOUSEKEEPING
Also in this issue...
6th Annual Salary Survey Questionnaire ... Pg. 33
Contract Cleaners:
How Indelible is Their Ink?

Contract Cleaners: How Indelible Is Their Ink?

by Gary Mullennix

Author's Note: I was privileged last July to conduct a seminar on this subject at the 26th Biennial N.E.H.A. Congress & Exhibition at the Arlington Park Hilton, Arlington Heights, Illinois. Sharing the editor's belief that the topic is of vital importance to every N.E.H.A. member, I was pleased to accept EXECUTIVE HOUSEKEEPER's invitation to prepare this condensation of the presentation. And just as I was delighted to talk with attendees at the Arlington Heights meeting, Huntington Laboratories will be glad to hear from Executive Housekeepers and administrators who have comments or questions after reading this article.

Gary Mullennix is President, Huntington Laboratories, Huntington, Indiana.

1

Do They Fit In With Voluntary Cost Containment Efforts?

I can walk into your hospital tomorrow and cut housekeeping costs by 15% to 40%.

In case the first sentence failed to jolt you even slightly, I will put it another way. Let us assume you have eighty people in the Housekeeping Department and I lop 20% from the payroll. Here is what it means:

$ 4.00	hourly wage
40	hours a week
$160.00	weekly wage
52	weeks a year
$8,320.00	yearly wage
16	employees cut
$133,120.00	employee wage cut
1.14	14% benefit cost cut
$151,756.80	yearly employee cost cut

Frankly, I do not know if I can really save your hospital that much money and still provide high quality housekeeping service. I doubt it. But, I have called your attention to the essence of the kind of sales pitch used by many contract management companies when they come knocking on the office door of a harried, cost-conscious administrator. However the pitch is structured, its main feature is a promise to save money . . . while getting the job done better or as well as it is being done by the in-house staff.

The fact that the promise contains more myth than miracle does not prevent the administrator from listening and hoping. The contractor, of course, knows he can deliver on any budget he quotes because the "big savings" will come from transferred work—often to Nursing or Engineering—and by simply stopping some work or contracting it out to still other companies.

The pitch and the promise is made daily by contractors everywhere. And, in too many cases, vulnerable administrators are unwittingly contracting their hospitals into greatly reduced levels of housekeeping quality as well as situations that quickly cost the jobs of many housekeeping supervisors.

For those who have not thought out the exact definition of a contract management company, here is one with the key words in italics: "A company that provides *contract service* including *equipment, supplies* and *supervision* for *a fee* while *managing* the hospital's *in-house* staff."

Contractors have full-time sales people working nationally. They call mostly on administrators, usually after a softening up process that involves monthly direct mail contact, trade magazine advertising, trade show promotions and sometimes even TV advertising. If you think they are not persistent, consider the fact that one contractor spent six years going after the University of Michigan's hospital complex. Do not make the mistake of thinking they have not tried to land your hospital or, at least, contacted it. If you are not concerned because you have not heard anything, that can be an even bigger mistake. Because by the time an Executive Housekeeper hears a contractor is on the way in, he or she is usually on the way out.

The contract proposal process tends to exclude those department heads most directly affected, who know the most about the problems involved. Housekeeping has the most to lose, except for the administrator who surrenders control of an essential department and gives up a source of much important information. Nursing Services is next, and may find itself with massive amounts of housekeeping work—after the contract has been signed. And that is certainly expensive housekeeping personnel.

Infection Control will be bypassed because contractors' methods often include shortcuts which their people are rigidly taught to take. They do it their way; it saves money. If Infection Control personnel do not have the opportunity to enter discussion before the contract is signed, they will not have the chance to amend it afterwards. The Infection Control Committee will find itself shut out of the process and left with little choice but to rubber-stamp approval of products brought in by a contractor. Product selection becomes a thing of the past. Other departments such as Dietary, Engineering, Central Services, Surgery, etc., all get similar treatment.

If knowing all this makes you wonder how the contract company can make a sale by calling only on the administrator, assistant administrator and the financial officer, bear in mind that until you started reading this article you may not have known it either. Once more, remember the pressures these people are under. The contractor never forgets. So, he arouses lots of interest by stating an ability to save enormous sums of money. He follows that door-opener by selling "Integrity" (one well-known contractor uses "Godliness" in every pitch), "Knowledge" (this means a survey as well as reams of proposal reprints and references), and "Service Attitude" (talking about monthly meetings, inspections, and shiny hallways and washrooms—especially in the administration area).

Administrators give several reasons for their interest in contract cleaners. Some are valid, some are partially so, and some are pure myth. Consider them and decide if they are valid where you are concerned and what you might do about it.

Cost leads everyone's list. You may be overstaffed. It happens in many institutions without being anyone's fault. But, it is up to you to determine how many people are really needed. Staff can be reduced through normal attrition, by not hiring new people, and by making some reassignments without causing ill will.

Contractors show—on paper—huge savings by quoting a cost based on the level of service they will provide and *not* on what is currently being performed. How many jobs is the House-

keeping Department now doing that are not really housekeeping functions—and who knows it besides you? Many supply costs are charged to Housekeeping which a contractor will not include. The contractor's proposal does not include project work. Window cleaning, for example, is a separate contract job. Many tasks are left to "other personnel," whoever they are. A competitive contractor will seldom blink at a 40% staff reduction if it is necessary to make the sale. However, such a cut leaves no employee pool to cover absenteeism or special projects. And quality has to take a nose dive.

Lack of communications causes many problems. It means lack of information about Housekeeping, its problems, and your proposed solutions. Administration may have no way to know if you are even aware of problems, much less able to deal with them. Some of the fault lies with the administration for not insisting on regularly scheduled meetings with set formats, but an effective Executive Housekeeper will be alert to a communications weakness and try to correct it.

Administrators speak of wanting to deal with professionals without defining the word. I think they want to deal with people who can get the job done. By the same taken, a "professional image" should not be overlooked. An Executive Housekeeper's office should not look like a repair shop.

Administrators speak of the quality of housekeeping. Do you know what the administrator means by "clean?" Do you know the administrator's pet peeves?

I have heard administrators say, "We must be spending too much. I see people standing around." How much is housekeeping costing? Should it be reduced? By how much? How and when? Have you discussed it with your administrator?

Contractors know all about professional images and they want to talk with your administrator anytime, anywhere, and make their pitch. Look again at those three key words: "Integrity," "Knowledge," and "Service." These words form the backbone of a proposal from a leading contract company. Let's examine parts of the proposal and see how they are designed to make the sale.

The first sheet of the proposal is a paper proclaiming "Certificate of Performance." It implies something official, but means nothing of the sort. It is signed by their own engineer, attested to by a secretary, and notarized or stamped to look like a legal document.

The proposal talks of forty-five years of experience. But, the hospital will get someone with a pretty small fraction of that experience. Until fifteen years ago, this particular company was not even in contract management.

They offer a "Microbiological Profile" that gives the impression of being a scientific document and may keep the administrator from consulting with Infection Control.

The contract proposal process tends to exclude those department heads most directly affected, who know the most about the problems involved. Housekeeping has the most to lose . . .

A nice list of references is provided, but who refers people to those who will speak of their failures and shortcomings? Amazingly, we learned the only reference check made in this sales effort was by the Finance Department to another hospital's Accounting Department. It is an unusual place to call about housekeeping, but if they had called the Housekeeping Department they would have ended up talking to one of the contractor's own employees. To get a balanced view, someone should have checked a hospital or two that had cancelled the contractor's services.

The proposal included an annual report that emphasized "Integrity" and "Service." It spoke first of Godliness, then service, and helping people develop. Finally, it mentioned the pursuit of excellence. It said profit is not a true goal, only a measurement. Can you see the emotional appeal for an administrator trying to run a nonprofit hospital whose aim is to provide high quality community service, to save lives and relieve suffering? Here is a company that says its only use for profit is to help people and measure success. But after they have measured, they do not give back any of that very solid profit. Their operating revenues were up 23% that particular year. However, their net income increased 39%. Profits were rising faster than their billings! Their return on investment was an incredible 29.2%, a rate that far exceeds what many companies would be happy with. And how does that return on investment compare with the interest on your own savings account?

Contract management companies use plenty of fancy language to say, in effect, that they do a lot of the very same training most hospitals already do. They also do something most hospitals should do, but most do not. They get administration involved. They make a great and valid show of communicating with every shift. The housekeeping staff is told about goals; it is positioned as a member of the health care team. When they clean, they know what they are cleaning. On this point, you must concede the contract management company's efforts are extremely valid and important.

The proposal, like the contract legalese, is quite specific. What is accepted is what you get. Nothing more. That is why both need to be studied by attorneys, whose emotions will not get in the way.

The following examples show how vital it is to scrutinize the wording in a contract. The contractor says the company will clean the sidewalk "directly in front of the front entrance." No mention is made of cleaning the side,

Contract management companies say they do a lot of the same training most hospitals already do. They also do something most hospitals should do: They get administration involved.

the side entrance, or even cleaning very far out. Or, surgery floors will be cleaned after all surgery is completed. Who does the very important job of cleaning between operations? Other personnel? It is not specified. Kitchen walls and vents will be washed three times a year. Once every four months. Floors will be cleaned daily, but there is no mention of how. Cafeteria chairs and tables will be cleaned by, you guessed it, other personnel. The laundry, too. Light fixtures will be cleaned on a scheduled basis, but no schedule is given. An outside contractor will do window exteriors. Inside windows will be cleaned twice a year only. Isn't your department doing a more complete job right now?

This particular contract is a gem. It absolves the contractor from any responsibility in terms of representing the hospital in any matter involving labor unions. Despite the cause of a grievance, everything remains the hospital's headache. In effect, everything is still the hospital's responsibility; the contractor merely manages. The hospital foots the bill, but has little authority. The contractor also tends to end up owning all supplies and equipment. The hospital pays full price for them, however, in addition to monthly "usage" charges.

Housekeeping staff loyalties are switched to the contractor, who hires and pays the workers with the hospital's money; the contract management company maintains and usually keeps their pay records. The contractor's fee is based on the payroll. How is it audited? In addition, the hospital pays to recruit new managers brought in by the contractor. And, the contract states that if the contractor is fired, the hospital cannot hire "its" managerial people.

A host of services now performed regularly and taken for granted will become special projects under the contract, but charges for them are not part of the contractor's fee base. They show up later—as surprises. Because these charges are spread out, some administrators simply shrug them off. Besides, the halls are invariably shinier outside their office doors.

The hospital pays surcharges and overrides on almost everything. This includes costs of all supplies used, their shipping charges, and also items such as parking when the contractor sends someone to visit (even if the visit is not requested). Besides salaries, taxes and benefits for employees, the contractor's fee will also call for enough funds to cover unemployment insurance—presumably for whenever the institution decides not to rehire the contractor.

Surcharges, overrides, and a fat fee for doing more or even as much for less? Not very likely. And, if space permitted, I could give you dozens of pages more on why not. But the fact remains that contractors make sales. They may soon sell you right out of a job . . . unless you take positive action now.

How To Solidify Your Own Position

It is not enough to simply poke holes in the concept of contract management. Their success is a matter of record. You have to recognize this as fact and apply the valid principles to the improvement of your managerial performance and the betterment of your own position. Start with the same three words they use and draw up a checklist. Apply "Integrity," "Knowledge," and "Service Attitude" to your job. Use what you now know about contract management companies to your advantage. Remember, too, the specific factors that keep the contractor profitable are strict adherence to standard hours, elimination of "other duties," and reduced equipment and supply costs.

Make up your own master plan based on the same components that guide the contractors. Here is the list: (1) the sale, (2) the survey, (3) the contract, (4) scheduling, (5) budgeting, (6) ratio of supervision, (7) inspections, (8) supplies and equipment, (9) professional image, (10) administrative rapport, (11) training and motivation of personnel, and (12) training and motivation of managers.

Your *contract* is your job description. It might help you to begin by rewriting it, incorporating "Integrity," "Knowledge," and "Service Attitude." An attachment should include an outline of your department's operation, including the number of personnel, a description of routine and "other duties," and the frequencies with which services are provided.

The points of your *sale* are the benefits to the hospital of the in-house staff. Detail them to your own satisfaction before meeting with your administrator and whomever else you report to. Make your sale and present a summary of your own *survey* outlining areas where you can cut costs by controlling hours. Discuss your contract and stun the administrator with a possible first-year savings along with a projected total multiplied over five years.

Find out the administrator's pet peeve regarding housekeeping. Do not defend a bad situation; solve it. If the administrator mentions a cleaning problem, attend to it personally. Make the administrative office area a showplace. Do things that will be very noticeable the next day. The floors, restrooms, and mirrors should gleam. You are investing time and supplies in your own future.

Provide written work *schedules* for full eight-hour shifts including break and lunch times. Schedule project work a month ahead. Work with Admitting to release some rooms each day for at least two hours for stripping and refinishing of floors.

Budgeting must be done on a daily basis. Establish standard daily working hours and record how many hours were used over and under this figure each day. Have employees write down their time in and their time out to the closest half-hour. Run daily totals and make daily comparisons, correcting the differences the following day.

As for *ratio of supervision*, once you have implemented eight-hour schedules and are keeping a close watch on staff utilization, the next step is providing adequate supervision. To insure full production from your work force, supervision is necessary. It is an expense you cannot afford to do without. Supervisors bridge the gap between you and your hourly workers, and they must be able to communicate effectively with everyone from administrative personnel to housekeeping employees. These individuals must be willing to pitch in with the work when necessary, train employees, and regulate supplies. Supervisors must be given a fair workload and the right number of workers in order to conduct proper inspections of each employee's work daily. Without such inspections and a willingness to pitch in, they will not help you. Your supervisors should have a tight daily schedule to follow and should turn in an established number of inspection reports each day.

The essentials in competing with these firms are knowing your job and communicating effectively with administration.

Inspections are the key to policing the quality of housekeeping. Housekeeping management should inspect weekly to measure the accuracy of a supervisor's daily reports. Monthly inspections should be made with other hospital executive personnel, and the high quality of housekeeping should be pointed out with pride. Maintenance and housekeeping inspections should be made jointly to determine needed repair and project work.

Successful service contractors use the best *equipment* possible. You should not settle for anything but equipment designed to deliver dependable service. Quality will prove economical in the long run. And, since good housekeeping begins "at home," equipment should be cleaned after each usage.

Contractors avoid the time problems involved in purchasing by supplying managers with only one line of products and insisting on its exclusive use. The

contractor's manager purchases nothing, and refers sales representatives to the contract company's office. I believe an in-house manager should—in conjunction with the hospital purchasing agent—decide on as few quality product lines as possible and not waste time with other sales reps or testing inferior products. An Executive Housekeeper must convince administration that quality—which includes products, training, and service—is worth a premium price.

A solid *professional image* on the part of a manager calls for a well-organized office and equally well-organized paperwork, personal dress that is consistent with that of other department managers, preperation for meetings in order to present points clearly and answer questions, and knowledge of all that is currently going on in management to be able to discuss it with others. If you expect a good salary and want your department to receive proper consideration and recognition, you must look and act the part of a professional manager.

Administrative rapport involves going out of your way to speak with key hospital personnel when you see them. Make notes on who they are, when you talked with them, and what you talked about. Double-check your key personnel list regularly. You will find those most often neglected tend to be the sources of most complaints. It is always better to communicate than defend.

Training and motivating personnel is essential to quality performance. New employees should be trained before assignment to a work area, not simply teamed with an "old-timer" who will often pass along bad work habits as well as good ones. The ideal system involves a supervisor assigned to training in classroom and one-on-one work situations.

Motivating housekeeping personnel is difficult at best, but there are tools available. Here is a list of satisfiers and dissatisfiers that may help guide your efforts:

Satisfiers	*Dissatisfiers*
Self-determination	Salary
Responsibility	Work Conditions
Achievement	Management or Institutional Policies
Earned Recognition	Behavior of Supervision
Personal Growth	Apparent Lack of Administrative Interest

Training and motivating housekeeping managers is another matter. Some formal education is necessary in order to handle routine management tasks. All the managers I know are high school graduates. A growing percentage of those I meet have college degrees. As more college-trained people enter the job market, it is likely that eventually most managers will be college-educated. Many administrators feel a college degree is necessary not only because of the budget and paperwork demands of the job, but to give the housekeeping manager the self-confidence needed to deal with other hospital professionals.

Whatever your educational background, if you are lacking in some of the knowledge needed to do your job take a look at the many available seminars. Make your selections and inform administration that you are attending, emphasizing the fact that you and your supervisors are constantly upgrading your skills.

No one should fear the contractors' supposed miracle. It is mostly a myth. The essentials in competing with these firms are knowing your job and communicating effectively with administration. An Executive Housekeeper willing to make the effort will carve out a highly rewarding career in an important field. As with all things worthwhile, you get as good as you give. But you have to work at it. ○

SL2ML2

HOSPITALS TRANSFERRING FROM HOUSEKEEPING SERVICES TO IN-HOUSE HOUSEKEEPING

Hospital	Approximate Date	
Herrin Hospital Herrin, Illinois	Prior to September, 1977	
Silver Cross Hospital Joliet, Illinois	" " " "	
St. Mary's Hospital Kankakee, Illinois	" " " "	
Hammond-Henry District Hospital Geneseo, Illinois	" " " "	
Doctors Hospital Carbondale, Illinois	" " " "	
Rockford Memorial Hospital Rockford, Illinois	" " " "	
Guernsey Memorial Hospital Cambridge, Ohio	" " " "	
Radford Community Hospital Radford, Virginia	" " " "	
McDonough District Hospital Macomb, Illinois	" " " "	(Was ARA)
Medical Cities Dallas, Texas	" " " "	
General Rose Memorial Hospital Denver, Colorado	" " " "	
Burlington Hospital Burlington, Iowa	" " " "	
Muscatine Hospital Muscatine, Iowa	" " " "	
St. Joseph Hospital Syracuse, New York	" " " "	
Irving Community Hospital Irving, Texas	" " " "	
Buffalo General Hospital Buffalo, New York	" " " "	
Forkosh Memorial Hospital Chicago, Illinois	" " " "	
St. Joseph Hospital Chicago, Illinois	" " " "	

Hospital	Approximate Date
Holy Name of Jesus Hospital Gadsden, Alabama	September, 1977
Emory University Medical Center Atlanta, Georgia	" " "
Southeast Missouri Hospital Cape Girardeau, Missouri	October, 1977
Hillcrest Baptist Hospital Waco, Texas	October, 1977
Presbyterian Hospital San Francisco, California	Late fall, 1977
St. Francis Hospital San Francisco, California	Fall, 1977
Galion Community Hospital Galion, Ohio	December, 1977
St. Agnes Hospital Fond du Lac, Wisconsin	February, 1978
Allef General Hospital Houston, Texas	January, 1978
Albert Einstein Hospital Philadelphia, Pennsylvania	January, 1978 (was Crothall)
Coweta General Hospital Newnan, Georgia	February, 1978
Allegan General Hospital Allegan, Michigan	February, 1978
Edward H. White Hospital St. Petersburg, FLorida	March, 1978
M. D. Anderson Hospital University of Texas Houston, Texas	February, 1978
Outagamie County Health Center Appleton, Wisconsin	February, 1978
St. Mary's of the Plains Hospital Lubbock, Texas	September, 1977
University of Washington Hospital Seattle, Washington	January, 1977 (was Red Top)

Hospital	Approximate Date	
Riverview Hospital Crookston, Minnesota	Unknown	
St. Agnes Hospital Fresno, California	"	(was Crothall)
Madera Community Hospital Madera, California	"	(was Crothall)
Rose Medical Center Denver, Colorado	"	(was AMS)
St. John's Hickey Memorial Hospital Anderson, Indiana	March, 1978	
Logansport Memorial Hospital Logansport, Indiana	March, 1978	
A.I. duPont Institute Wilmington, Delaware	Early 1978	
Independence Hospital & Sanitarium Independence, Missouri	May, 1978	
Union Hospital Terre Haute, Indiana	May, 1978	
Katherine Hamilton Mental Health Ctr. Terre Haute, Indiana	April, 1978	
Coatesville Hospital Coatesville, Pennsylvania	August, 1978	
Coffee County Hospital Burlington, Kansas		
Flow Memorial Hospital Denton, Texas	September, 1978	
Memorial Hospital of Dodge County Fremont, Nebraska		
Christ Hospital Oak Lawn, Illinois	November, 1978	
Northampton Accomack Memorial Hospital Nassawadox, Virginia		

Hospital	Approximate Date	
Memorial Hospital Colorado Springs, Colorado	January, 1979	
Emanuel Hospital Portland, Oregon	March, 1979	(American Management Services)
University of North Carolina Memorial Hospital Chapel Hill, North Carolina	June, 1979	
Detroit Central Hospital Detroit, Michigan	July, 1979	
Peninsula General Hospital Salisbury, Maryland	August, 1979	(Crothall)
Mercy Hospital Port Huron, Michigan		
David Brotman Memorial Hospital Culver City, California	August, 1979	
Whittier Community Hospital Whittier, California	August, 1979	
Hollywood Community Hospital Los Angeles, California	August, 1979	
Queen of the Valley Hospital West Covina, California	August, 1979	
Sam Houston Hospital Houston, Texas	July, 1979	(AMS)
Memorial City General Hospital Houston, Texas	July, 1979	(AMS)
Moody House Foundation Galveston, Texas	August, 1979	
Rosewood General Hospital Houston, Texas	September, 1979	(AMS)
St. Catherine's Hospital Kenosha, Wisconsin		(AMS)

Hospital	Approximate Date	
University of Pennsylvania Hospital Philadelphia, PA.	December 31, 1979	
St. Luke's Hospital Denver, Colorado	December 31, 1979	
St. Francis Hospital East Monroe, LA	January, 1980	
Tri-County Hospital Springfield, PA	January, 1980	
Glenwood Hospital West Monroe, LA	March, 1980	
Children's Hospital Denver, Colorado	March, 1980	
Cuyahoga Falls General Hospital Cuyahoga Falls, Ohio	February, 1980	
Deaconess Hospital Milwaukee, Wisconsin	February, 1980	
Grady Memorial Hospital Chickasha, Oklahoma	April, 1980	
Southwest Detroit Hospital Detroit, Michigan	March, 1980	
Palm Harbor General Hospital Garden Grove, California	May, 1980	
Gardena Hospital Gardena, California	May, 1980	
Porter Memorial Hospital Valparaiso, Indiana	June, 1980	
Emanuel Hospital Portland, Oregon	1979	(Was Red Top)
Union Hospital Terre Haute, Indiana	August, 1980	
Oklahoma Osteopathic Hospital Tulsa, Oklahoma	August, 1980	

Hospital	Approximate Date	
St. Francis Hospital Wilmington, DE	November, 1980	
Northridge Hospital Foundation Northridge, CA	September, 1980	
Parkview Community Hospital Riverside, CA	September, 1980	
Community Hospital of Sullivan Co. Harris, NY	October, 1980	Was Custom Environmental Svs.
Aurelia Osborn Fox Hospital Oneonta, NY	October, 1980	" " " "
Marion Health Center Hospital Sioux City, IA	November, 1980	
West Texas Hospital Lubbock, TX	January, 1981	
Women's Hospital Houston, TX	January, 1981	
Shenango Valley Osteopathic Hospital Farrell, PA	January, 1981	
Hocking Valley Hospital Logan, OH	January, 1981	
Feather River Hospital Paradise, CA	February, 1981	
St. Francis Hospital Medical Center Peoria, IL	February, 1981	
Louise Lisner Home Washington, D. C.	August, 1981	
Davis County Hospital Washington, IN	August, 1981	
St. Joseph Hospital Patterson, NJ	October, 1981	

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HOUSEKEEPING

OUR 50TH YEAR

"... For all their claims concerning management expertise, housekeeping know-how, job efficiency, the contract housekeeping firms are no more housekeeping magicians than an in-house housekeeping staff..."

Contractual Cleaning firms have recently been making significant inroads into large buildings, hospitals, elementary and high school districts, public and private universities and colleges with promises of ... "*We can do your custodial maintenance for less and eliminate all of the other alleged problem areas such as labor negotiations, personnel problems — including benefits, insurance, pensions, payroll, etc....*

These firms are cashing in on the precarious economic state of business and institutions today. Boards of directors, boards of regents and governors and school boards have instructed their respective executives and administrators to begin reducing cost, particularly custodial maintenance costs, because it represents a substantial portion of their respective budgets.

The "We-can-do-it-for-less" pitch certainly is attractive to these executives and administrators. But, indeed, can they really do those same tasks as the in-house staffs and earn a profit?

The answer is no ...

... unless the in-house staff is almost totally inefficient.

The contract custodial maintenance firm requires a 30% profit margin (12% profit and 18% overhead.) Well, that takes care of thirty cents of the custodial maintenance dollar. Fifty-five cents of that dollar goes for labor, eight cents for supervision, four cents for supplies, and three cents for equipment.

What about the "incidentals"?

Many in-house staffs are involved in other tasks in addition to custodial work: moving furniture and equipment, loading and unloading supplies on the shipping and receiving dock, operating and inventory in central stores, delivery of equipment supplies to the various sections of the business or institution other than custodial equipment and supplies, preparing rooms for meetings, seminars, setting up tables and chairs and removing and storage of same, running errands — from getting the paper to picking up lunches for the administrative staff — chauffering, and doing minor repairs to furniture and equipment.

The list of additional tasks is almost endless ... particularly if the housekeeping staff is not unionized.

Can a contract housekeeping firm do the same housekeeping tasks, plus the additional tasks that are provided by the in-house housekeeping staff? Can they make their 30% profit, and keep the cost to the business or institution less than the cost of their in-house housekeeping staffs? Of course not!

The contract firm usually makes a proposal after making a survey of the housekeeping tasks associated with that particular operation: how often during a week or month they intend to do various housekeeping jobs, how they will accomplish them, and the cost.

In other words, they are providing for job specifications, methods of operation, quality control procedures, production and performance standards, scheduling, stocking, and control and allocation of supplies.

Compare the two approaches

If you wish to compare the cost

(See CON, page 20)

By LEWIS V. BERRY

Mr. Berry is director of Operational and Maintenance Services, Chicago State University, Chicago, IL.

....OVER....

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CON . . .

(continued from page 19)

of in-house and contract services, make a survey and write the specifications, including all the additional tasks that are performed by the in-house staff. The specifications should include that the contractor retain the in-house staff for at least 90 days. Also, have the contractor bid on that set of specifications and see if the cost really is less.

If I may be permitted to relate a personal experience concerning the contractual versus the in-house staff housekeeping cost:

Our institution is a public, medium-sized university, with a population of 7,000 students, eight buildings, and a staff of 43 building service (housekeeping) personnal. Our approximate square footage is 725,000/625,000 in vinyl asbestos tile. The remaining square footage is in carpet and sealed concrete.

Our former vice president for administrative affairs requested that our Physical Plant Department investigate the possibility of hiring a contractor. The objective was to effect reduction of housekeeping costs and cost of personal services. Such costs include housekeeping maintenance, payroll, benefits, pensions, health and welfare.

We utilized the same set of specifications that we used for our in-house housekeeping staff, setting forth scheduling and priority setting, strict production and performance standards, procedures, personnel training, quality control and inspection standards and procedures, stocking plus allocation of supplies.

Also stipulated was the requirement that the contractor retain our in-house staff until the end of the union contract period. The housekeeping contractor and the employees union would have to work things out subsequent to the end of the contract period.

The hitch . . . quality control

We arranged to have all the bidders inspect and walk through the job site at the same time. We provided a period for them to ask questions concerned with specifications.

All five of the contractors expressed concern with the provision in the specification that gave us the necessary latitude to maintain quality control. They all indicated that they were not too interested in the bidding because of our specifications. Now, let me remind you that these were the same set of specifications that we were using in directing and operating our own in-house housekeeping staff!

One of the marketing representatives of the largest and more wellknown firms suggested (with affirmative head nods from the others) that maybe what we needed was not the total service, but rather their expert supervisory services. He explained that his firm would provide a supervisory person to direct an in-house staff.

The representatives from the other four firms agreed. Two representatives indicated that they had other appointments, and excused themselves. We asked the remaining three representatives to individually write down the approximate cost of the supervisory service and place the estimates in sealed envelopes. The envelopes would not be opened until the representatives left.

The assistant director asked them just what their supervisor could provide in the way of supervision that our supervisor could not. All three representatives explained that their supervisors had management experience and know-how in the housekeeping field.

Expensive supervision

We opened their envelopes after they had left, and found that the cost to us for a supervisory person would be $2,000 per month for two of the firms or $24,000 per year, and $2,100 per month from the other firm or $25,200 per year. Of course, contracting for a supervisor to direct a staff of 43 housekeeping personnel at a cost of $24,000 or $25,200, in this case, was ridiculous then . . . and *is* ridiculous now!

Our supervisor had considerable managerial experience and experience in the housekeeping field, as well as considerable experience in the overall building maintenance field. He was also an excellent manager. His approximate salary was $19,000 per year. By the way, that would be the approximate salary paid by the contractor to their supervisor. The balance charged by the contractor would be profit.

We forwarded the information on to the vice president. Two weeks later, he directed a memorandum to us indicating that we would continue with our in-house housekeeping staff.

Message is clear

The message in this experience is very simple: That contract firms cannot do the same job that the in-house housekeeping staff can do for the same cost . . . not to mention a lesser cost. The cost to the business or institution is more.

The contract cleaning firms have capitalized in many instances on the lack of communication between the executives and administrators and the managers and supervisors of their respective housekeeping functions. The executives and administrators must be kept informed of the cost of operating the in-house housekeeping staff, which includes the housekeeping functions as well as the many additional tasks performed by that staff.

All of this assumes that the in-house operation is efficient, and quality control is maintained for the housekeeping and additional tasks.

To organize and operate an efficient housekeeping function is not overly difficult. In the October, 1977 issue of Building Operating Management Magazine, I authored an article titled, "Optimizing Custodial Efficiency", in

(See CON, page 22)

CON . . .

(continued from page 20)

which I discussed five task areas for an efficient housekeeping function.

The National Executive Housekeepers Association offers, through many universities and colleges, a 320-Hour Certification Program that is concerned with the efficient operation and management of a housekeeping function for housekeeping and management personnel in the nonprofit institution, school, hospital and hotel industry.

There are many workshops and seminars held throughout the nation concerned with the efficient operation and management of a housekeeping department.

This is exactly what a contract cleaning firm is selling. Only from them, the cost is more.

Management responsibility

The inroads being made by the contract cleaners into large buildings, institutions and industry are due, in large, to their aggressive marketing techniques. And, because many administrators and executives are unaware of the functions of their own in-house housekeeping staffs.

The contract maintenance firm has comparable materials, and equipment costs with that of the management of the in-house staff. They have as many of the same, if not more, personnel problems, both at the supervisory and worker levels. Any additional tasks performed and not covered in the job specifications agreement between the firm and the business or institution are provided at an additional cost including a healthy profit . . . many times exceeding 30%!

For all their claims concerning management expertise, housekeeping know-how, job efficiency, the contract housekeeping firms are no more housekeeping magicians than an in-house housekeeping staff.

The contractor cannot do the same jobs done by the in-house staff at the same level of quality, even when he can pay less and reduce staff. Not to mention, if he must retain the in-house staff, pay union wages, and that cost is less than the cost of the in-house housekeeping staff.

Let the executives and the administrators compare apples with apples and oranges with oranges. The contractors are selling apples and will provide the same.

The in-house housekeeping staff is providing oranges. □

Contract housekeeping: hospital survey cites reasons for termination

BY JOSEPH D. BROWN, Ph.D.

HOUSEKEEPING

Based on a survey of a small group of hospitals, this article attempts to discover the reasons why hospitals have discontinued their contracts with outside firms in an effort to help hospital administrators avoid the pitfalls that can be associated with contracting for housekeeping services

Editor's Note
Turning over the day-to-day management of certain hospital departmental functions to an outside contractor is an alternative that has been available to hospitals for many years. If he thinks that it makes good management sense, today's administrator can negotiate agreements with contractors to provide services ranging from food to pharmacy to physical therapy.

Housekeeping was one of the first hospital services that outside contractors offered to provide, and the success of most such arrangements may be reflected in the large number of hospitals that currently delegate this service to others. According to the most recent (1975) American Hospital Association figures, no less than 11.9 percent of the nation's hospitals have come to accept contract housekeeping as a way of management life.

But contract housekeeping has not worked in all hospitals that have tried it—probably for as many reasons as there are variables within hospital and contractor organizations and in relationships between the two. The article that follows is based on a study that attempted to discover why a small group of hospitals that decided to try contracting for housekeeping services eventually discontinued the arrangement. It is presented for the purpose of helping hospital administrators who are considering such services to avoid the possible pitfalls that lurk in imprecise comparative costing, inadequate performance safeguards, and insufficient controls. The reader should not infer that these experiences are in any way generally representative of results that might be expected with hospital contractors for housekeeping or any other hospital service.

The purpose of the survey that is described in this article was to determine why hospitals initially hired contract management firms for housekeeping services and why they later dismissed them.

A list was obtained of 74 hospitals that had hired and subsequently fired contract companies in recent years. These hospitals were dispersed throughout the United States and they varied in bed size from under 100 to more than 500, with more than half of the hospitals in the 100- to 249-bed range; nearly a third in the 250- to 499-bed range.

The study began in July 1980 with a letter to the administrator of each listed hospital. The letter explained the purpose of the survey and that the administrator or other individual who was responsible for hiring and terminating a maintenance firm would be telephoned to discuss the nature of their negative experience with contract housekeeping.

Of the original 74 administrators who were contacted, 12 were not interested in participating, 24 could not be reached, and 38 respondents were ready, willing, and able to take part. The findings reported here are based on, and are subject to the limitations of, this admittedly small sample.

THE QUESTIONNAIRE

The first section of the questionnaire that was used for the telephone interviews asked why the outside contractor was hired and terminated, and each respondent was asked to explain the particular circumstances of their hospital. The second and final section contained 13 statements about the contract itself, operational factors, and the personnel who were provided by the contractor. Respondents were asked to agree or disagree with each statement and to rate—on a scale of 1 to 10—whether or not the contract company had delivered the services that it had initially promised to provide.

WHY THEY HIRED

The principal reason that was given for hiring a contract company by nearly half of the respondents was the inability of hospitals to find and to retain a good executive housekeeper. Secondary reasons for hiring an outside firm included expected cost savings, better quality housekeeping, and the availability of proven housekeeping methods and expertise. Other reasons that were given by a minority of administrators included their desire for fewer employee problems, the influence of other management people, an end to having to purchase maintenance supplies, expectation of good accountability of services rendered, better trained people, and cuts in administrative time.

A typical comment about hiring a contract firm was: "We listened to their sales story, and we felt a company could bring us a lot of support services that we couldn't afford ourselves. Secondly, we felt they would bring us experience in management that we just didn't have at the time. Third, they seemed to provide a sense of professionalism."

WHY THEY FIRED

The two main reasons given for the termination of contract services were a lack of cost-effectiveness and a lack of accountability. Additional reasons

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included poorer quality housekeeping, a lack of housekeeping control, the hiring by the hospital of a qualified supervisor, too much management turnover on the part of the contractor, failure to cut administrative time/supervision, and conflicts with the contractor's assigned executive housekeeper.

Administrators' comments about the cost-effectiveness of the contract services included: "It was not cost effective. The actual cleaning job was one of the key things. It just wasn't being done." And, "We felt that by eliminating the contractor we could decrease our costs by cutting out their management fee."

One administrator expressed the lack of accountability this way. "The hospital wasn't very clean. We had a lot of trouble and many patients complained. In addition, we didn't receive an effective response from the company when we would notify them of difficulties or problems."

Another respondent mentioned trouble over the contract agreement. "(We had) escalating costs in the contract that began to jump dramatically. We had a construction project going on, and as the contractor began to take over the responsibility of the new square footage, the contract was changed several times. We felt the changes were a little bit more than they were worth."

ADMINISTRATORS' ATTITUDES

Despite the foregoing negative comments, when administrators responded to questions about the contract in the second section of our questionnaire, most of them felt that the agreement itself was easy to understand. However, many respondents, (particularly from small hospitals) said that they were unable to identify specific costs in the contract for supplies, equipment, personnel, and the management fee. A majority of respondents agreed that the contract was easy to renegotiate as the hospital's needs changed.

More than three-quarters of the respondents gave negative answers when asked if the purchasing and infection control departments were free to select housekeeping products, and only half of the hospitals surveyed knew if legal counsel had reviewed the contract before it was signed.

Another administrator said the hospital had thought that certain levels of cleaning had been agreed upon, but when they analyzed the statements in the contract, they did not conform with what had been verbally agreed upon.

OPERATIONAL FACTORS

In terms of operational factors, slightly more than half of the administrators felt that the contract company had met their housekeeping standards. On the other hand, more than half of all of the respondents indicated that other hospital departments were dissatisfied with the contractor's housekeeping services. A much smaller group felt that they had lost control over housekeeping functions. Both the dissatisfaction of other departments and the loss of control were problems more often felt by large hospitals than small ones.

When the respondents were asked if they had realized the savings that were predicted to result from the contract, 16 administrators said they did not save any money by employing an outside firm, 13 felt they had saved, and 9 others did not know.

CONTRACTOR PERSONNEL

When surveyed on their attitudes toward contractor personnel, a majority of hospitals said that as much time was spent administering the housekeeping function after the hiring of a contract firm as had been spent before. The same majority felt that the contractor's housekeeping personnel lived up to expected performance standards. Most of the respondents were satisfied with the firm's housekeeping director; however, more than one-half were dissatisfied with the high turnover rate among contractor-supplied housekeeping directors.

Following is one commentary on personnel problems. "We had some difficulty because of the fact that the housekeeping people did not feel that they were working for the hospital. They felt that they were working for someone else, and they were reluctant to take directions from us. Even though they were our employees, and only supervised by the outside firm, they immediately viewed that firm as being responsible for giving them directions."

In commenting on housekeeping management turnover, one administrator felt that his hospital became a training ground, and that as a result, there was a lack of continuity in the services provided. Another said that if the hospital were to sign with another outside firm, the contract would have to spell out and guarantee the length of time a good manager would remain at the institution. A third said the firm's manager was good, but that the services delivered were of poor quality because hospital budgetary restrictions made it impossible for the manager to hire qualified personnel. Finally, the larger hospitals surveyed were less satisfied with the contractor's director of housekeeping than were smaller institutions.

CLOSING QUESTION

In seeking an overall opinion from the hospital administrators who were involved in the hiring and/or terminating of contract maintenance companies, we asked them to rate the degree to which the contract company had delivered the services that it had promised. On a scale of 1 to 10, the average rating that outside contractors received was 6.3.

In order to understand why some administrators rated the contract companies higher or lower than others, we measured each person's answer to the closing question against the responses they gave to each of the measured opinion areas in the questionnaire. The main reasons cited by respondents for giving companies lower overall performance ratings were the dissatisfaction of other hospital departments with the contractor housekeeping services and the administrator's feelings that the hospital was losing control over the housekeeping department. Other factors that contributed to low performance ratings were the failure to save money as predicted, dissatisfaction with the assigned director of housekeeping, and the feeling that the personnel who were hired by the contract company did not live up to the standards expected by the hospital.

Based on cross measurements of all of the survey respondents, it became clear that operational factors outweighed opinions about the contract itself or the personnel who were hired by the contractor when it came to forming a final judgment of the outside housekeeping company. ■

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WE COULDN'T HAVE SAID IT BETTER OURSELVES

Institutional Management

Publisher's Perspective

Ray Tobin

Offers advantages over contract services

Housekeeping should be run as an in-house operation

In discussions with institutional administrators throughout the country, I have met many who have recently been led to believe that a contract cleaner can perform all housekeeping services at a lower cost than an in-house department, and that the administrator will no longer be bothered with housekeeping problems.

On this point, I believe it is important for me to take a direct and firm stand: A well-run in-house housekeeping department has many advantages to offer over a contract cleaning service.

An in-house staff executive is able to select the best products to properly maintain the institution and achieve longevity of furnishings and building apparatus.

With an in-house department, management maintains direct control over all work. This control is abdicated when an outside contract cleaning firm is brought in. In addition, the loyalty of the staff is controlled by the contact maintenance firm whose major intent is to achieve a profit by limiting the size of the staff and the overall expense of the maintenance products used.

Suddenly, you will find that the *esprit de corps* of being part of a highly motivated team, professionally trained in accordance with management's, needs is lost.

A properly trained in-house staff is conveniently available to handle emergencies, special projects and last minute changes. Most executive housekeepers are also responsible for managing the in-house laundry operation as well as general housekeeping.

The in-house staff, therefore, has the advantages of the very important factors of control, flexibility, efficiency (when properly managed), loyalty and interdepartmental relationships. And in security matters, there is a great advantage in working with a staff that has been carefully screened and scrutinized by your own executive housekeeper.

Another plus is the availability of the executive housekeeper to the administrator to handle peripheral duties. It is extremely satisfying to know that the executive housekeeper, at no extra cost to the institution, can help handle details in interior decoration, carpet selection, culture testing, research or related technical matters such as waste disposal, infectious control, relocation planning and budget preparation.

It is a great asset when you, as an administrator, know that you are working with an executive housekeeper who answers directly to you and that he or she is qualified in these essential duties.

You must continuously stress to your executive housekeeper that he or she should be receptive to new developments in supplies and equipment. Labor saving devices are continually being developed and the executive housekeeper, properly trained and educated, can budget and control all costs in the operation of your in-house department. This efficiency reduces non-productive time and increases effectiveness in achieving results.

Even though large contract housekeeping firms have made inroads in institutions, I still must abide by my convictions that contract maintenance is an extremely poor substitute for the direct control of a properly trained in-house staff.

Institutional Management

Publisher's Perspective

Ray Tobin

Executive housekeepers: Vital link in the management chain

Institutional managers are constantly seeking easy solutions for complex problems. One of the so-called "easy solutions" is turning toward a contract maintenance firm to replace the housekeeping department.

However, administrators opting for this seemingly cost cutting move, should take a close look at what they're losing. An in-house housekeeping operation proves to be a valuable management asset. And the executive housekeeper should be treated as key administrative manager.

A positive working relationship between the director of housekeeping, the rest of the administrative staff and department heads is essential to the future growth and well being of a major institution. If these very important relationships are weak and lack direction, the total operation will suffer.

Frustration will exist within the housekeeping staff.

Without honest and sincere delegation of both authority and responsibility, the management team becomes a dictatorship. Let's look at your own relationship with your executive housekeeper.

1. Does your executive housekeeper receive monthly copies of the financial statement? Perhaps you just tell them whether its up or down compared to last year's performance.

2. Did your executive housekeeper help you prepare this year's budget?

3. Does your executive housekeeper have access to you whenever necessary? Does your executive housekeeper join your staff meetings?

4. When did you last inspect the premises of your entire institution with your executive housekeeper?

5. When did you last tell your executive housekeeper that a good job was done?

I confess that my questions are not fair because the manager who has done all of these things is as rare as an eskimo in Florida.

But that doesn't change a thing. You should be treating your executive housekeeper like an important member of your management team.

Today's executive housekeepers need management skills never required before. And as administrators of mammoth departments in multi- million dollar, public oriented facilities, housekeepers must be flexible, diplomatic, quick thinking and have a lot of common sense. They must be skilled managers of people and programs as well as teachers, accountants, buyers and more.

Providing leadership for the training and development of housekeepers (to meet today's added responsibilities) is the task of the National Executive Housekeepers Association. The nearly 50 year-old association is the only professional organization in housekeeping.

The association works with colleges and universities to develop educational training for young people. It sponsors meetings, a national publication (*Executive Housekeeper*) and a National Executive Housekeepers Association Convention to give present and prospective housekeepers the opportunity to exchange ideas and techniques. N.E.H.A.'s efforts have done much to make today's director of housekeeping a true executive.

Why don't you talk to your executive housekeeper today and make certain that he or she knows you regard them as an integral part of your institution's management team? In addition, remind them that it is important for them to continue to keep on top of the latest techniques and developments in housekeeping.

They can do this through your encouraging them to become members of the N.E.H.A. and participate in the various activities and programs offered by this fine association. It would be well worth your while to have your institution sponsor the membership.

HUNTINGTON LABORATORIES INC
P.O. Box 710 Huntington, IN 46750 • Lansdale, PA 19446 • Dallas, TX 75217

SL-2M-K3

the argument against Contract Cleaning in Hospitals

by Emma Louise Schroeder

1. *The contracting of housekeeping services is contrary to the best interests of the patient.*

Unity of Purpose May Be Jeopardized

The hospital employee is strongly conscious of how his work affects the patient. He is concerned about how he does his work in relation to the patient—how he does his work in relation to attending doctors, nurses, and other services. He is further concerned with when he does his work in relation to patient and attending staff—knowing that he must not cause delays, discomfort, or inconvenience to patient or staff members.

The contract employee, on the other hand, will be strongly conscious of man-power hours, a factor which has been strongly stressed to him by the contractor. Man-power hours mean cold, hard cash to be paid out. The contractor and his employees will be more concerned with meeting schedules, getting jobs done at their convenience with less concern about delays, discomfort and inconvenience to patient and staff.

Goals May Be Different

The hospital employee will be performing his work out of dedication to duty first. He will repeat his work as many times as it is necessary. For instance, at St. Vincent Charity Hospital there is an emergency admitted around the clock every 15-20 minutes. The ground floor porter may have to respond 15 to 20 times in his 8-hour day to clean the floors in the emergency unit and the emergency ramp. The contract employee will be performing a service for only a fee, and will carry out his work according to the terms of the contract. He may be more concerned with cutting corners to cut costs.

Divided Loyalties May Become Apparent

The hospital employee will perform work on his own volition, work requested by his immediate supervisor, and work requested by nurse, doctor, or other staff member because he will recognize them as superiors. The contract employee may not react so favorably to dual supervision. He will have strong loyalty ties to his employer, and will realize that loyalty is owed to an employer in return for a pay check. He is dependent on his employer for his job as well as its continuance, promotions and salary increases. The hospital's needs, therefore, may not be answered as they are required. Further, the contract employee may feel more independent and less obligated to honor hospital rules and regulations of which there are many.

Close Coordination and Cooperation May Be Lacking

The hospital employee will re-schedule work, change sequence of work to suit the needs of the hospital without undue concern about delays. The contract employee may not care to re-schedule work or sequence of work due to pre-determined schedules and methods firmly set by contract. Delays mean time and time means money to the contractor.

Teamwork May Be Wanting

In a hospital environment team work is an essential factor, each service being interdependent on the other. A hospital employee is a member of the hospital family around which many duties and obligations are entwined for the benefit of the patient. A hospital employee's assignment must mean more than a place where his work is performed. The contract employee may be considered an outsider or a stepchild to the hospital family and he may never be adopted into it. He is bound by contract to perform prescribed work and the privileges of the hospital family may never be extended to him.

Hospital employees are granted many privileges and benefits which the contractor couldn't feasibly grant to his employees. Such as: low cost meals, discounts on medicines, vacations with pay, sick pay benefits, death pay benefits, retirement plan, paid holidays, uniforms and maintenance of same, locker rooms and lounges, library benefits, sponsored bowling leagues and other sports, personal health clinics, emergency treatment as well as other. These benefits tend to create happier employees. The contract employee, in not being a privileged employee, may be subject to low morale in his work and in his relation with hospital employees.

Mrs. Schroeder is the executive housekeeper at Saint Vincent Charity Hospital, Cleveland, Ohio.

Patients' Right to Security, Privacy and Safety May Be Subject to Violations

The incoming patient entrusts his person, personal possessions and reputation to the hospital. The hospital employee normally undergoes pre-employment health tests, security checks, work and character reference check. The unknown factors concerning contract employee's character, integrity, work purpose, and past record may constitute a real threat to hospital patients, staff, and hospital property.

II. The contracting of housekeeping services is contrary to sound economy.

It is difficult to justify that a contractor can claim to do a better job, meet overhead expenses, and still make a profit—providing cleaning services to the hospital are at a lower cost as they claim.

Contractor Has Unusual Overhead and Operating Expenses to Meet

Contractor has to pay rent usually in a high rent commercial zone. If he maintains a warehouse he will have to pay in a high rent industrial zone or perhaps he is buying his business property and would have mortgage, interest and taxes plus insurance payments to meet. His utility bills will have to cover light, heat, water, phone and extensions, and possibly an intercom system if he is a big operator.

Transportation and travel expenses will be involved if he holds contract in several states as many contractors do. He will have food and lodging plus miscellaneous expenses to pay for his home away from home.

Entertainment and goodwill gifts will come up which today is an acceptable business practice. None-the-less, someone has to pay for these items.

Advertising and public relations expenses. Contractor will have to let the public know that he is in business.

Delivery expenses which may include initial cost of cars, trucks, and planes. The plane for delivery is not far-fetched. According to an article appearing in the Sanitary Maintenance Magazine July, 1961, issue, a contract cleaners in Washington, D. C. purchased a plane in which to make better contacts with customers. Then there are license fees, insurance fees, maintenance and gas and oil expenses, plus truck drivers' salaries and plane pilot's salary. This covers only delivery expenses.

Furnishings for contractor's business and cleaning services.

Equipment for warehouse and cleaning services.

Secretary and/or office force to send out billing, administer payroll, social security, withholding tax, etc.

Sales commissions and sales expenses. Most contractors maintain a sales force.

Contractor must have on hand money for employees' wages and fringe benefits. He also must have on hand money for supplies and equipment which items are usually furnished to hospitals and included in the contract. Contractor must have available money for State Industrial Insurance, Public Liability Insurance, Assumption of Risk Policies among others. The contractor has to make a profit and pay himself a salary in accordance to the standard of living to which he has become accustomed.

III. The contracting of housekeeping services is contrary to the best interests of the community.

The hospital of today is a stand-by service for the community. A stand-by service is a demand service requiring standard of living to which he has become accustomed.

A hospital employee will be motivated by an emergency for his services. He is well orientated in responding to an emergency realizing that deaths, births, sudden illness, and disaster in the community do not recognize time schedules. The contract employee may not be so motivated since he is well orientated as to timing his work and carrying out standard work procedures as scheduled. Ray Brown, Vice President for Administration, University of Chicago, says, "Hospitals are personal service enterprises rendering individualized care to sick people—there is little opportunity for mechanization and automation of hospital work." Another administrator says that business efficiency must be subordinate to good patient care. However, this does not indicate that inefficiency and wasteful practices should be condoned. John McGibony, M. D., writing in Principles of Hospital Administration, says that the hospital purpose is community service. A business organized for profit would best be served by a single executive with a great deal of authority. Such authority would at least be occasionally exercised coldly, objectively, and arbitrarily. An organization set-up with service to the community as a principal object must deal with the general public with more subjective and understandable approach. Administratively, then, hospital activities may be divided into pockets—they are a means to an end and not the end in itself. All exist for one purpose, care of the patient, and are indivisible if that care is to be adequate and efficient. Therefore, eliminating the housekeeping department and substituting contract cleaning means cutting out an essential division of the hospital organization.

The members of the community expect their hospitals to be foremost in medical and scientific advances—foremost in design and construction, foremost in facilities for patient care, but they resist and resent foremost business methods and efficiency especially if their bill is ready upon dismissal. More specifically to tie in with housekeeping—a slower tempo of movement is less upsetting to a patient in bed as opposed a super-skilled fast moving cleaner in a sick room.

Another aspect of the community interests is that today's hospital utilizes the services of the handicapped person. The limbless, partially blind, deaf persons, as well as the lower I. Q. persons who are slow in learning and slow to acquire skills but whose personal qualifications are such that they make good employees honest, dependable, and dedicated. The contractor promises in most instances allegedly better trained, higher calibre people, which may mean the displacement of these persons who have a right to work and who would never find employment elsewhere—certainly not in industry where production and profit are of primary importance. The community looks to the hospital for employment of the handicapped. In many instances handicapped employees have recovered or have been rehabilitated in our own hospitals from their illnesses and injuries. The advantages offered

by the handicapped in stability and dedication, far outweigh the advantages that may exist in a super-skilled, fast moving cleaner. In the housekeeping department at St. Vincent Charity there are 61 persons—7 of whom are handicapped. These 7 may never make top specialists, but they will always be top generalists.

The geographical location of the hospital in the community plays an important role in the employment picture of the non-professional. For instance, St. Vincent Charity Hospital is located in a lower socio-economic level neighborhood where the unemployed abound in great numbers. The hospital is in its 100th year in this location. During the war years and during the lean years the people in this area responded to the call of the hospital and now in better times are responding in turn to the call of the people.

Pressure groups also exert an influence on the employment picture—minority groups and various political groups as well as welfare and social agencies. In Ohio, for example, the Ohio State Law requires that employable persons work for their relief checks. The State Welfare Director has authorized that the County Welfare Departments should assign men and women to work relief projects at hospitals. One of these hospitals is St. Vincent Charity Hospital.

The community interests are mentioned here for they are of importance. Considering these factors, several articles on contract cleaning stated that the first thing the contractor did upon receiving a contract was to clean house of all housekeeping personnel and replace with his own crews. One contractor mentioned that he maintains crews that travel between several hospitals within a city. Displacing an established staff in some hospitals would have detrimental effects on the community. Also, if a contractor has a large business extending over several states, it means that money is flowing out of the community instead of circulating in it to help stabilize the economy. The community in many respects supports the hospital and should be entitled to the business of furnishing supplies and equipment to the hospital.

IV. The contracting of housekeeping services is contrary to the basic principles of good hospital administration.

Hospital administration should have total control for total management of its activities, facilities, personnel and finances.

The fact that the cost of a housekeeping department, represents only 3 per cent to 5 per cent of the total cost of operating the hospital doesn't justify "farming-out," so to speak, this small but important segment of the hospital organization, hereby losing control or partial control. This small segment, the housekeeping department, affects every member of the visiting public, every patient, every staff member.

It is difficult to justify to the public that the problems of a housekeeping department are too vexing, too unpleasant or not important enough for a busy hospital organization to cope with; that it can best be done by others, especially outsiders. (Better management in the housekeeping department yields greater satisfaction all-round and lesser problems. A top level manager for the housekeeping department is the essential ingredient.)

Contracting housekeeping services is an outright admission of inefficiency somewhere along the line of management. The recruitment, selection, development, and training of responsible department managers is a direct administrative responsibility. Managing a housekeeping department is no different than managing any other department or business. Many of the same principles of good organization apply; that is, planning, organizing, staffing, directing, and controlling. In many industries managers change jobs without the benefit of personal knowlege about an industry's particular product or service but they do know the principles of good organization and how to apply them. This point can best be emphasized by the role of the contract cleaner. According to the literature at hand, very few of them have had any extensive cleaning experience, but they are selling their ability to organize work in hospitals. (The argument that housekeeping managers are scarce is unfounded, because many persons with management potential are available.) Another important point—an unscrupulous department head or manager may be dealt with more readily, less painlessly and less perilously than an unscrupulous contractor who is bound by a legal document containing a time clause.

The union question should also be of importance to administration. For instance, in Cleveland all contract cleaners are unionized. None remain in business unless they become affiliated with the local union. (There are no Cleveland hospitals with contract cleaning at present.) The Taft-Hartley Act, at the present time, specifically excludes non-profit hospitals from its provisions which protect or encourage collective bargaining. (Some states excepted.) Introducing unionism through the contract cleaner may involve hospital administration in a labor relations situation for which it is not prepared and which may force them to resort to the services of a labor relations counselor which is both costly and time consuming.

Worthy of note is a news item which appeared in Medical World News in the June 21, 1963, issue stating that "Semi-private accommodations in New York City's voluntary hospitals may soon jump to as high as $60.00 or $65.00 a day because of a new law extending collective bargaining rights to the city's non-professional hospital workers (MWN, May 24.) A spokesman for Local 1199 of the Drug and Hospital Workers Union concedes that New York's voluntary hospitals are frequently in financial difficulty, but states that this is not our concern. It's time to pay the hospital workers a living wage. The president of one of the city's biggest non-profit hospitals says that before the year is out most voluntary hospitals in New York will be forced to push up their rates by as much as 30 per cent to 40 per cent."

Hospitals may be short changed by contract cleaners in value received considering the following factors. The designation—the housekeeping department is an all embracing term including many operational tasks as well as cleaning tasks. The organizational duties in a housekeeping department may include any or all of the following as they are carried out at Charity Hospital.

Moving furniture and equipment of all descriptions.
Adjusting bedrails, window shades, curtains, tracks, casters, drapery rods, lights, windows, screens.
Delivering linen.

Messenger and delivery duties.
Hanging Christmas decorations.
Minor repairs—oiling squeaky casters, door hinges.
Changing light bulbs.
Changing mattresses.
Collecting, sorting, and disposing of garbage and rubbish.
Maintaining storage facilities for non-burnables.
Maintaining storage facilities for mattresses, extra beds, furniture and equipment.
Answering demand services of every description over a 14-hour period.
Assisting departments with special exhibits for special events.
Making beds in dormitory areas.
Installing and removing draperies, cubicle curtains, shower and bath curtains and handling storage of same.
Odor control.
Pest and rodent control.
And then cleaning!

Housekeeping costs and cleaning costs cannot be used interchangeably, although they are used synonymously in many cases. Housekeeping costs reflect the over-all operational costs of the department's duties plus the cleaning costs. These operational duties may not be considered in the contract and may go from Tinkers to Evers to Chance in a buck-passing field play, or else they may be delegated to the maintenance department where higher wage rates prevail because of the crafts involved. A highly paid electrician may be changing a light bulb formerly changed by a porter, or a carpenter may be hanging a Christmas decoration. To further show the wide utilization of housekeeping employees, they are also effectively used as valuable members of the disaster committee, fire committee, and safety committee. These functions, important and vital as they are to the hospital, may be considered as non-productive work by the contractor and excluded in the work contract.

V. The contracting of housekeeping services is contrary to acceptable ethics in the health field.

It is a violation of understood principles in the health field. Namely, that the professions within the health industry are expected to subordinate interest in pay to the tendering of services to the patient. Any financial benefits that are to accrue through increased efficiency and better work organization should rightfully and morally accrue to the benefit of the patient and the supporting community either in lowered patient cost or improved facilities. The financial benefit should not accrue to any individual. The only beneficiary in a hospital should be the patient. The practice of exploiting any segment of the health field for undue profit when it is unwarranted is not in the best interests of the patient or the community. Specifically that segment for which we are personally responsible—rendering to the patient—the highest and best quality housekeeping services at the lowest possible cost. Engaging a contractor and absorbing his high overhead and high operating costs plus the high profit involved to achieve better housekeeping is terribly and totally wrong. Rationalizing that the housekeeping department is a low cost department and a hospital organization can afford this, or rationalizing that a housekeeping department has high nuisance value and someone else should shoulder the responsibility is also totally wrong. In the final analysis a contractor can do no more than a hospital administrator, for the contractor promises to put in a capable manager to organize and oversee the work, and he is subject to the same human and economic forces that the hospital administrator is subject to also.

Other important factors

Contract cleaners and those who call themselves Sanitation and Hospital Housekeeping Consultants are primarily salesmen. They will always be, first, last, and always salesmen. Sales means dollars and they are doing a good job selling! Unfortunately, at the expense of human suffering. This is a direct reference to the increased cost of housekeeping services in a hospital as it relates to the patient. Contract cleaners are opportunists who are realizing a high degree of achievement in their quest for personal gain by capitalizing on the hospitals' alleged management deficiencies.

Unfortunately, all of us contributed to their entry into the field, in a sense, for we failed many times to come to our own defense when the contract cleaner and self-styled sanitation consultant grossly distorted facts concerning hospital housekeeping services and costs. Many articles written by these commercial interests appeared in such publications as HOSPITAL MANAGEMENT, Institutions Magazine, and the Wall Street Journal. It has to be really big business to capture front page headlines in the Journal. It was a $600,000,000.00 business in 1962. According to the Wall Street Journal this figure includes the industrial and the hospital housekeeping figures. In 1962 there were 160 hospitals using contract services. Of this U. S. total 73 were federal hospitals. All other categories of hospitals had a 2.4 per cent with contract cleaning as opposed to a 16.8 per cent total for federal hospitals. Some editors of the above publications claimed they had to print commercial interest articles because there were no articles forthcoming from hospital housekeepers. One editor alleged that he had to plead to the National headquarters of one housekeeping organization requesting housekeepers to write articles in their defense and interest.

You and I are charged with the responsibility of keeping materialism out of the housekeeping field. You and I are charged with serving the housekeeping field at the highest level of professional standards. A parting thought: we well know that a medical consultant is an M. D. — an expert practicing in the medical profession. An engineering consultant is an engineer—an expert practicing in the engineering profession. A hospital housekeeping consultant should be a hospital housekeeper — an expert practicing in the housekeeping profession. A doctor contributes time, interest, and substance to the advancement of his profession. An engineer does the same. A hospital housekeeper should contribute time, interest, and substance to the advancement of the hospital housekeeping profession. Anything that a contractor or consultant can do, we can do better and at a lesser cost! You and I are the experts in hospital housekeeping and let's keep it that way! ■

PLANT MAINTENANCE

by John C. Gardner

Pros and cons of contract cleaning

During the last twenty years, there have probably been more grey hairs and stomach ulcers caused by the pros and cons of using contract cleaning than any other problem in the management of the educational physical plant. With housekeeping budgets in the million-dollar range in the larger plants it is no wonder that some become curious about the feasibility of using contract cleaners. Especially when the quality and quantity of cleaning is questionable and there is evidence that the plant is wallowing around with outdated and haphazard cleaning methods.

Contract cleaning has become a big business. The success and continued growth of the contract cleaning business leaves little doubt about its place in the housekeeping field. There is no question that some of the big and well-managed contract cleaning firms are more productive than some of the cleaning staffs found in some of our institutions. There is also no doubt that the contract cleaner has to make a profit. This is the crux of the matter. As managers, it is our duty to get the maximum services and goods for every educational dollar spent. Therefore, we must assume that our hourly labor costs are the same and if we are big enough purchasers our material costs are going to be approximately the same. Remembering that labor costs amount to about 95% of the cleaning costs, then where is the profit coming from? I will tell you where: it comes from savings in labor, or shortages in providing the right amount of labor depending on the integrity of the contract cleaner and the customers' inspectors.

Studies indicate a 14% to 58% saving through the use of planned housekeeping programs where better methods and better organization have been achieved. Management survey companies will agree that there is a 25% or more waste of manpower at most of the institutions that they have surveyed. With labor costs making up about 95% of the cleaning costs there is little doubt that any effort put into developing a planned housekeeping program will pay off in a reduction of labor costs. The large cleaning contractors recognize these facts and concentrate their efforts on time and motion studies and engineering their cleaning operations. If your program is not based on standardization of products and cleaning methods then you are ripe for an exposure to the exercise of the pros and cons of contract cleaning.

Pro Contract Cleaning

If your operation requires less than one man for cleaning;

If your operation requires less than ten people for cleaning, and is not supervised by a cleaning supervisor;

If your operation is spread out geographically, so that it is difficult to make the necessary visits;

If you are located in a tight labor market;

If you have serious transportation problems;

If your present cleaning program is beyond salvaging;

If the expansion of your plant is exceeding your ability to recruit personnel;

If you have temporary occupancy;

If you have a partial occupancy of a large building that has a contract cleaning operation;

If you want to be rid of the administrative problems related to cleaning, payroll, hiring, firing, unions, training and personnel problems.

Cons Contract Cleaning

If your plant is large;

If your present operation is being run efficiently;

If you do not want to lose control of the present flexibility of your cleaning operation;

If you want complete control of the type of individual hired for cleaning;

If you do not like the idea of being surprised by "extras";

If you do not like the idea of contract cleaners being able to "sell" your contract to other cleaners;

If you do not like the idea of free competition being frozen out by big operators;

If you do not like the common technique of "skip cleaning",

If you do not like the idea of not getting immediate attention to complaints;

Continued

Mr. Gardner is Director of Buildings and Grounds, Columbia University, New York City. His column about plant maintenance appears monthly in AS&U.

If you do not like the idea of a strike being called that is not of your making;

If you prefer to put any savings on housekeeping back into the educational budget rather than into a contract cleaner's pocket;

If you want to maintain control over the quality of products used;

If you prefer not to have outsiders having unlimited access to your buildings during off hours.

Three Types of Contracts

Contract cleaning services may be all inclusive or they may be broken down into the following categories; (1) Window cleaning; (2) Interior glass cleaning; (3) Refinishing floors periodically; (4) Regular floor maintenance; (5) Servicing toilets; (6) Cleaning executives' suites; (7) Carpet cleaning; (8) Boiler room and machinery space cleaning; (9) Parking field cleaning; (10) Structural cleaning; (11) Cleaning radiation exposure areas; (12) Rough cleaning—removal of debris; (13) Furniture polishing; (14) Dry cleaning.

Contract cleaning services can be arranged on three types of contracts:

Cost Plus—The cost plus contract is based on an itemized accounting of all cleaning costs. Included are labor costs, overhead and profit. This type of contract gives the owner some control over the cleaning operation and relieves the involvement of uncertainties that may not have been covered in a fixed price contract.

Fixed Price or Lump Sum—As the name implies, the contractor agrees to perform for a stated number of dollars. The fixed price contract provides a fixed rate payable monthly for cleaning services as spelled out in a contract. The one advantage of this type of contract is the firm price which is helpful for budgetary purposes. However, there are always the "extras" to contend with.

Combination Contract—A combination contract is nothing more than a lump sum price for certain areas of work and a cost plus for others. The most common arrangement is a fixed rate for general office, corridors and toilets cleaning and a cost plus rate for the president's suite.

How to Select a Contract Cleaner

1. Check him out with Dun and Bradstreet.
2. Check with the institutions that he is presently working for or those he has worked for in the past.
3. Look at the type of cleaning he does for his clients.
4. Does he have a rating form for evaluating the quality of his cleaning?
5. Find out through interviews what caliber supervision he has.
6. Does he have a formal training program for his personnel?
7. Does he use modern equipment and methods?
8. Does he perform any research work on new materials, equipment and methods?
9. Does he have a good central office set up that can be reached at any time?
10. Does he have depth in his administration or is it a one-man operation that is run out of his hat?

"If maintenance managers do not keep pace with modern techniques, the contract cleaner may offer a better service at lower cost."

Unhappily, the expansion of educational facilities or the request for a better quality of cleaning usually results in the demand for more help instead of an examination of the efficiency of the present staff. With this lack of business insight, the result is overstaffing inefficiency in many self-cleaning operations. On the other hand, the contract cleaner has the profit motive and the strong desire to outproduce the do-it-yourself operation. The result is that the contract cleaners are going to have to be reckoned with more and more. If cleaning managers do not keep pace with modern business practices and technologies, the contract cleaner may offer a better service at a better cost.

If contract cleaning is decided on, do not buy it at a discount. Be very careful of the low bidder. Remember that proper supervision is the key to either choice—contract or do-it-yourself.

Pitfalls In Specifications

Writing the specifications for a contract cleaning operation should be no different than the specifications for your in-house operation. In either case the specs should exist.

The following pitfalls in specifications should be watched:

1. Avoid nebulous words or clauses "shall assist" "support" "reasonably" etc. If the specs are subject to interpretation they are subject to misinterpretation.
2. Be careful of overlapping responsibilities.
3. Make sure all records are kept in your office—records off the site sometimes do not exist or are difficult to get when there is a dispute or cancellation of the contract.
4. Watch out for turnover in key personnel, don't become a training ground for the contractor.
5. Over specification and excessive frequencies can lead to unnecessary expense. In most cases the contractor will cheat on performance if it is over specified.
6. Improper supervision on either side can lead to problems. Have a provision for formal inspections by both parties and periodic outside inspections by a third party.
7. Incomplete or inconsistent accounting can be troublesome. Make provision for at least monthly billing and accounting.

There cannot be any generalization about contract cleaning being good or bad. Any decision whether to use a contract cleaner must be based on a sound analysis of all the facts. A wise manager will thoroughly examine all these facts before he makes a decision. The manager who thinks he can engage a contract cleaner and forget about it thereafter is living in a fool's paradise.

THE MILTON S. HERSHEY MEDICAL CENTER
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Maintenance and Operations 717 534-8028

July 31, 1981

RECEIVED SEP 2 1981

Joseph D. Brown, Ph.D.
Director of Business Research
Professor of Marketing
Ball State University
Muncie, Indiana 47301

Dear Dr. Brown:

I read with interest your article on contract housekeeping in the July 16, 1981 issue of Hospitals magazine. Your survey findings confirmed our decision in 1976 to improve our housekeeping service rather than go to contract services.

We fortunately took the time to properly evaluate the alternates. See attached copies of memoes. With Administrative support and patience we have been able to establish a Housekeeping Department (Environmental Health Services - E.H.S. for short) that, I believe, can be a model for hospitals or institutitions such as ours.

Charles Miller, our Manager of Environmental Health Service has authored a book on "How to Organize and Maintain an Efficient Hospital Housekeeping Department" which is published by AHA. See enclosed brochure. With this book, all hospitals should be able to handle their own housekeeping department at an acceptable level of cleanliness and cost.

Thanks for an encouraging article.

Sincerely,

Robert M. Henry

Robert M. Henry
Director of Physical Plant

RMH/dv

cc: C. Miller
EHS File

AUG 1981
BUREAU OF BUSINESS RESEARCH

"Caring . . .
is what we do best."

Ravenswood Hospital Medical Center 4550 N. Winchester at Wilson, Chicago, Illinois 60640, 312/878-4300

Affiliated with the University of Illinois
Abraham Lincoln School of Medicine

February 2, 1979

Gary Mullenaix
Vice President
Huntington Laboratories
Huntington, Indiana

Dear Mr. Mullenaix:

Thank you for your excellent article on Contract Cleaners in Executive Housekeeper.

Having formerly been a part of a contract management situation for four years, I can identify with the many comments that revealed "contract" agreements that hospital administration never understood. I have made a point of sending your article directly to two Administrator associates that are involved with contract services.

Last year, I competed with my former contract service for my present position. Our hospital administration has never been sorry they rejected the proposal.

Thanks again for your support to Executive Housekeepers, and for your advice to be progressive and approach the position with professionalism and integrity.

Sincerely,

John Antonsen

John Antonsen
Housekeeping Director
Ravenswood Hospital Medical Center

JA/jt

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STATEMENT OF

KENNETH T. BLAYLOCK
NATIONAL PRESIDENT

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

BEFORE

COMMITTEE ON VETERANS' AFFAIRS
U. S. HOUSE OF REPRESENTATIVES

ON

OMB CIRCULAR A-76
AND ITS BIAS TOWARDS CONTRACTING OUT
BOTH IN POLICY AND IN PRACTICE

OCTOBER 20, 1981

The American Federation of Government Employees, AFL-CIO, is pleased to have this opportunity to appear and testify before the House Committee on Veterans' Affairs. AFGE represents over 700,000 personnel throughout the Executive Branch of government, and is the exclusive representative for approximately 110,000 employees in the Veterans Administration.

At the July hearing before the Subcommittee on Oversight and Investigations, AFGE testified on the problems with contracting out in

general and on the devastating effect contracting out would have in the VA health care system. Today, we would like to focus our remarks on OMB Circular A-76 and examine precisely how that circular contains a built-in bias in favor of contracting out government work. In addition to this structural bias, A-76 has been consistently implemented so as to favor contracting out.

In issuing Circular A-76, the Office of Management and Budget was in part quite candid in admitting its bias in favor of contracting out. OMB's Bulletin 81-15 on A-76 declared that it was the Administration's general policy to rely on "private enterprise to supply the products and services the Government needs." (Paragraph 4.) The bulletin, published in the July hearings, further proclaims that "the Government should not compete with its citizens." (Paragraph 4.) However attractive at first glance, this is an appeal to emotion and not to logic.

Continuing to have VA hospital work done in-house does not "compete" with private citizens, because the in-house work is the business of the Government and not that of private contractors. For example, when a VA Medical Center has some dirty laundry to wash, it is under no greater obligation than Mrs. Murphy to send it to the corner laundry. (It would, of course, be a different matter if the Medical Center laundry suddenly started soliciting the business patrons of the corner laundry. That would be a genuine example of Government competing with private industry. We know of no such action by any Medical Center laundry.)

Even if one agrees, as a matter of policy, that in general

Government should rely on outside contractors for its goods and services, one has to admit that A-76 is biased in favor of that policy. In determining whether that policy is wise in practice, we have to examine A-76 to see how this policy is implemented in conjunction with other principles, such as reducing the cost of Government care, maintaining the control of the workforce by Government managers, and preserving Governmental functions. To be fair and balanced, A-76 should take all these factors into proper account. Unfortunately, it does not. As a result, A-76 amounts to little more than blind, unyielding prejudice against performance of Government work by Government employees. For the VA hospital system this prejudice would be disasterous.

Circular A-76 refers to some functions as "inherently governmental" and says that these functions must be performed by Federal personnel. (Paragraph 4b.) AFGE couldn't agree more. Unfortunately, the circular fails to provide a usable and comprehensive definition of what is inherently governmental. The reason for this failure, in our opinion, is basically that the drafters of A-76 want to leave open the possibility of ultimately contracting-out almost any function.

Before this attempt by OMB to force the VA to implement A-76, we would have thought that medical and hospital care for veterans of our armed services, many of them suffering injuries sustained in the defense of their country, would have a prime example of an "inherently governmental" function. Obviously, OMB sees a much stricter limit on that definition.

The delivery of medical and other hospital assistance, together with rehabilitative services to veterans is really a part of the Government's continuing responsibility for national security. Veterans only come from one activity--service in the armed forces of the United States of America. If there is any activity of Government that meets the test of an inherently governmental function, it is the responsibility of direct patient care and those support functions (like food services, laundry and housecleaning) that have a direct impact on the quality of medical care provided to veterans.

In the past, OMB has approved the contracting out of the writing of an agency's budget and even the statement of the agency's mission. This happened at the Energy Research and Development Administration's Fossil Fuel Division. Clearly, such functions are inherently governmental by any reasonable definition. These are functions which the Government through its elected and appointed officers must do itself in order to assure accountability. OMB's approval of contracting out such functions, however, demonstrated just how biased it really is in favor of contracting out virtually everything.

One would assume that national defense is one "inherently governmental" function, and, indeed, A-76 contains several references to national defense. (See paragraphs 5f(1) and 8b.) In practice, however, A-76 contracting out so adversely affected the Department of Defense, that the House Armed Service Committee was compelled to recommend statutory restrictions on DoD's contracting out. In 1979, Congress enacted those restrictions for a one-year period and made them

permanent law a year later. (See section 806 of Public Law 96-107 and section 502 of Public Law 96-342.)

This Congress, the Armed Services Committee recommended tightening the law to require a certification that contracting out would not adversely affect mobilization readiness, emergency contingency missions, or anticipated requirements in the event of a war. For all its references to national defense, OMB opposed the Armed Services Committee's attempt to safeguard defense in 1979, in 1980, and again this year. We believe that this also reflects OMB's prejudice against in-house performance.

A-76's relentless bias in favor of contracting out, both as announced policy and in actual practice, is revealed by the contracting out of the Hawthorne Army Ammunition Plant in Nevada. Although the Defense Contract Audit Agency identified substantial underestimates of labor costs in the contractor's bid, the contract was awarded anyway and the in-house capability at the ammunition plant was destroyed. The contract has since been adjusted upward by more than the $5.2 million that was, under the A-76 analysis, supposed to have been saved by contracting out. Moreover, there are reports that the contractor has failed to meet performance requirements with significant effect on operations of both the Navy and the Army.

In its report to the Armed Services Committee, the General Accounting Office noted that an accurate cost estimate should have barred the contracting out (B-202157, PLRD-81-19.) Circular A-76, however, fails to contain any requirement of accurate cost estimates or

to give either the managers of local facilities or the employees through their representative, access to information on cost comparisons so that they can spot obvious deficiencies.

It was a history of abuses like that at the Hawthorne Ammunition Plant that convinced the Armed Services Committee, and the Congress, that A-76 was so disposed towards contracting out that it simply could not provide a balanced approach to protecting vital governmental interests.

A-76's lip-service to "inherently governmental" functions is mirrored by its references to cost comparisons.

The March 29, 1979 memorandum for A-76 to the agencies provides that "relative cost must be given appropriate consideration in decisions between in-house performance and reliance on private commercial sources." (Paragraph 2.) Defenders of A-76 like to pretend that this means that cost-effectiveness governs the choice between performance in-house and by contractor. Even if lower cost were an appropriate sole criterion governing hospital care for veterans--and we believe it is not--the OMB Circular in fact makes no real effort to have genuine cost comparisons. Once again, A-76's bias in favor of contracting out almost completely undercuts other governmental interests, like decreasing costs where feasible.

At the heart of any genuine cost comparison is the statement of work. Unless the agency requires the contractor to meet the same job requirements that are currently performed by Federal personnel, the contractor can easily "underbid" by lowering the level of care. In the VA hospital system, of course, this would be a calamity.

For example, requiring rooms to be cleaned twice-a-week instead of every day obviously lowers cleanliness. But it would provide a "savings". If that standard is really acceptable, however, then the in-house costs should be based on twice-a-week service also. In most cases, of course, budget shortages have already required VA employees to perform so many different tasks that the actual work requirements of each task have been reduced to the minimal level acceptable. If twice-a-week cleaning were tolerable it would already be applied in-house, so that those employees would be free to do other duties.

Incomplete statements of work have frequently been cited by the General Accounting Office as a prime area of abuse in contracting out. GAO's report on the Hawthorne case also discussed contracting out at the Air Force Academy. There GAO found:

> For one of the Academy's buildings, which contains a floor area of almost 1,000,000 square feet, the statement of work omitted most of the tasks required to clean 3 of the 6 floors and 8 of the 10 stairwells. Also, the specifications showed that an area to be vacuumed weekly in the field house was about 13,000 square feet when in fact it consists of about 56,000 square feet.

As a result, the three-year contract price had to be increased by about $708,000. Nonetheless under A-76's built-in bias, the incomplete statement of work was sufficient to justify the contracting out.

VA itself also fails to require precise statements of work for the services to be contracted out. The latest prototype statement of work for hospital services contains only these minimal requirements. In areas like dietetic services the VA obviously can not be satisfied with allowing the contractor to perform just minimal requirements.

For example, the VA's prototype statement of work fails to make any provision for special diets such as those involving low-salt or diabetic prescriptions. These "special diets" are often prescribed for a majority of hospital patients. Yet, VA has failed to include them in their prototype statements of work.

What patients and employees obviously need, however, is legislation in which Congress imposes on the agency a real requirement that statements of work be accurate and complete. That legislation should also guarantee employees through their representative both access to the information and meaningful involvement in writing the statements of work. A-76 fails to contain these safeguards.

Another reflection of A-76's prejudice against performance by government personnel is its conspicuous failure to require that the in-house cost estimate be based on the most efficient organization and staffing. In practice, GAO has found that cost estimates are based on current staffing and organizational patterns, thereby penalizing Federal employees for what may be needless layers of managerial bureaucracy.

In addition, in-house estimates often are based on the needlessly complicated and expensive procurement systems of the General Services Administration or the Defense Logistics Agency. GSA's mark-up, for example, is 21% of the wholesale price to GSA of the procured materials.

A contractor, on the other hand, can just shop down at the local wholesaler. It is hardly fair to punish the VA employees because OMB imposes a fixed 21% markup for goods ordered through GSA.

The House Armed Services Committee was so dismayed at this practice of simply rubberstamping the agency's current organizational and staffing practices, that its statute restricting contracting out requires that the cost comparison be based on "the most efficient and cost effective organization" of the function to be contracted out. This requirement ensures that any cost savings will be genuine and not an illusion designed simply to guarantee contracting out. OMB, however, opposed this requirement.

The circular also inflates the cost of in-house operations by arbitrarily adding on 20.4% as a figure for retirement costs including the so-called "unfunded liability." This figure is sheer guesswork; OMB has never established its validity. It is more than three times the figure (7%) used in earlier versions of A-76. OMB has never required that the unfunded liability of the Social Security system, which is used by contract employees, be added to the contractor's cost. Nor does A-76 impose any estimate of the eventual welfare costs to the government when contract employees whose employer provided no pension plan finally retire.

In fact, A-76's treatment of retirement is an excellent example of how biased it is in favor of contracting out. Although guesswork, the 20.4% figure for in-house retirement costs is in theory based on the total, "dynamic" cost to the government of the civil service retirement system. This in effect forces the in-house cost estimate

to include the cost of retirement over a thirty-year period while the contractor's cost estimate is based solely on his outlays for the period of the contract. Legislation is needed to require that the in-house costs and contractor costs are for the same period.

If A-76 were serious about the relative cost of performance by Federal personnel versus contracting out, it would also require that the expense of the cost studies and processing a reduction-in-force be added to the contractor's prices because no contract could be let without these costs. The A-76 cost comparison handbook also, in effect, lops 40% off the actual cost of severance pay, homeowner's assistance, pay rate retention, relocation and retraining expenses, and the physical inventory required to implement the contracting out by requiring that the comparison be based on only three-fifths of the costs. Once again, OMB thereby deflates the cost estimate for the contractor.

If cost-effectiveness were a genuine goal of the circular, A-76 would bar the kind of increases in contract price that are now routinely given contractors in succeeding years or, as we have seen, in the initial year when the statement of work has to be corrected. Another effective check on escalating contract prices would be an absolute requirement that an agency retain a core in-house capability. Although A-76 refers to in-house core capability, it lacks either an appropriate definition of core capability or a specific requirement to maintain such capability. As a result, operating managers at the local level must accept a contractor's increased costs, whether fair or not. These problems existed before A-76, and it is unlikely that the failure to address them was accidental. VA, of all places, needs legislation

that, at least, requires the retention of core capability.

Once an agency function is contracted out, A-76 prohibits it from being brought back in-house unless there is 10% savings in personnel costs and a 25% savings in capital equipment. Once again, A-76's supposed emphasis on cost effectiveness gives way to its bias in favoring of contracting out functions and keeping them out.

Moreover, once a contract has been awarded to a small business concern, A-76 provides that it will not be reviewed for conversion to in-house preformance. This has led to unfortunate circumstances where the small business defaults or is otherwise unable to perform the service, but the Government is denied the opportunity to ascertain whether in-house performace would now be cheaper. An example of this involves the contracting out of housing maintenance at Blytheville AFB, Arkansas.

Many observers have noted that personnel ceilings appear to be the driving force behind much contracting out, even when costs to the Government actually increase as a result. The drafters of A-76 fully understood this relationship. The preceding version of A-76 barred outright any contracting out to circumvent ceilings but the drafters revised the circular so it only referred to contracting out "solely" to comply with personnel ceilings. (Paragraph 6d(3)) This allows the fabrication of other reasons to contract out when the primary motive was circumventing the personnel ceiling.

The most important bias in A-76 towards contracting out is its failure to provide for enforcement, even of its own biased requirements. Time and again, AFGE has sought to enforce A-76's own language in

court only to be met by OMB's objection that the circular has no force of law or regulation. (When ordering VA to comply, however, OMB doesn't say A-76 is only advisory.) In addition, OMB argues that decisions by agency heads under A-76 cannot be challenged. Even if challenges were allowed, the circular lacks both specific standards that are precise enough to serve as the basis for review and any requirement that affected parties can avail themselves of information which only the agency possesses. Legislation is obviously required to meet these needs.

The only appeal currently allowed under A-76 is inside the agency. (Paragraph 11.) This insures that any agency with its heart set on contracting out will successfully do so simply because pressure will be brought on those making the ultimate decision. Indeed, past experience in other agencies has shown that the people deciding the appeal had no background in administering the function being contracted out and thus had no frame of reference from which to view critically any objections to the agency's study.

Under the A-76 Cost Comparison Handbook, parties are generally given five working days to appeal. Given the months of perparation for the cost comparison, five days is a meaningless amount of time. This arbitrary five-day limit, however, discourages appeals and thereby increases the bias in favor of contracting out--even when that contracting out violates A-76.

Although AFGE believes that A-76's references to cost comparisons are largelya smokescreen designed to mask the circular's goal of increased contracting out, we recognize other effects as well. By omitting requirements on scope of work but concentrating on cost effectiveness, A-76

rewards those contractors who pay their employees the least. Frequently, these are not the most responsible contractors. The entire A-76 approach favors the letting of contracts to low-bidders, competent or not. Here again, inadequate and incomplete statements of work are often at the heart of the problem.

For example, the contract for the low-bidder on food services at Lowry AFB, Colorado allowed the contractor four hours to correct hygenic deficiencies. In other words, a contractor had four hours from when an inspector found the soup was below a safe temperature to remove and replace that soup. Military personnel eating at the contract food services sustained several waves of botulism. Although it is always difficult to establish conclusively the source of any food poisoning, the statement of work allowing a four-hour correction period suggests an immediate suspect. A-76 should have an enforceable requirement that prevents such an obviously inadequate statement of work.

We commend this Committee and its distinguished Chairman and ranking minority member for their continuing attention to the problems which A-76 implementation is causing the Veterans Administration. As you know, we applaud the Committee's initiative in amending the veterans compensation bill to bar use of scarce VA funds to pay for cost studies.

We have focused our testimony on the various ways in which OMB Circular A-76 is biased, both in policy and in practice, towards contracting out. We have pointed out how A-76 does not even live up to its own minimal standards of fostering cost-effectiveness. We would not want, however, to leave the Committee with the impression that AFGE believes cost-effectiveness should govern contracting out in the Veterans Administration. A single-minded focus on cost-

effectiveness, even if implemented fairly, would destroy other principles which are especially important in the Veterans Administration. These principles now require legislative protection.

AFGE urges that this Committee report out legislation which will:

(1) prevent medical care and other benefits for veterans of the armed services from being sacrificed either by direct budget cuts or through the guise of contracting out;

(2) prevent the contracting out of either direct or indirect patient care;

(3) prevent the effects of veterans preference from being diluted through contracting out;

(4) preserve the control of Government managers over the entire VA workforce, in-house and contract;

(5) preserve the stability in the VA workforce which Federal personnel now provide;

(6) ensure that any contracting out permitted under the above standards also meets rigid cost-effectiveness requirements, including accurate and complete statements of work and the most efficient in-house organization and staffing; and

(7) ensure that the statutory requirements will be fully enforceable and not subject to bias in favor of contracting out.

Although we have focused on the bias in OMB Circular A-76, no one should forget that the VA has already engaged in contracting out by using its own authority under title 38 of the United States Code. And, as might be expected, many of the same problems arose. Incomplete statements of work, greater costs, inadequate service, and destruction of in-house capability have already occurred on a smaller scale. My colleagues with me, who work in the VA system will have more to say about that, but we urge that any legislation govern the VA's authority under title 38 as well as A-76.

I want to note that the VA's contracting out places VA medical services at the risk of possible strikes by contract employees seeking better working conditions from the outside contractor. It's perfectly legal for contract employees to strike, and the fact that so many contractors are not organized increases the likelihood of strikes. Many studies have shown that the most likely time for a strike is when employees first set up a union and negotiate their first contract. Federal employees, of course, are barred by law from striking. More important than legal prohibitions, is the dedication of VA employees to their work--dedication that now causes them to go to the hospital during blizzards and power outages just in case they are needed.

An increase in contracting out at VA would also raise the possibility of graft and corruption. The employee-manager relationship in a Government agency provides almost no opportunity for corruption. The large sums involved in letting contracts, however, and the intrusion of the profit motive present the opportunity for graft when contracting out gets underway. It would sadden me to think that any of the scarce funds available for vital VA programs would be wasted through graft and corruption.

I want to thank you for the opportunity to once again appear before this Committee and pledge AFGE's continued support in your efforts to control contracting out in the Veterans' Administration.

PROCEEDINGS

OF THE

THIRTEENTH CONSTITUTIONAL CONVENTION

OF THE

AFL-CIO

DAILY PROCEEDINGS AND EXECUTIVE COUNCIL REPORTS

WASHINGTON, D.C.

NOVEMBER 15-20, 1979

AMERICAN FEDERATION OF LABOR AND
CONGRESS OF INDUSTRIAL ORGANIZATIONS

Contracting Out

RESOLUTION NO. 119—By American Federation of Government Employees.

WHEREAS, The AFL-CIO Executive Council in February 1977, adopted a policy position on the contracting out of public work which reads as follows:

WHEREAS, Nothing is more basic to the role of the American labor movement than the defense of a worker's job and the guaranteeing to him of equal protection in terms of working conditions. For public employees, this protection is now jeopardized by the contracting out of their work to private business contractors. Public employees are told, in effect, that if they bargain for increased wages and fringe benefits and insist on a decent standard of living, the public employer will contract out the work. They are told it can be done cheaper by private business contractors. Standards of workplace decency that have taken years to establish are threatened with overnight extinction when the employer decides to contract out work, and

WHEREAS, Private business contractors—both large and small, organized and unorganized—are willing accomplices. They stand ready to perform work that has historically been performed by public employees. Frequently they are initially willing to perform this work at a cheaper rate and without fringe benefit costs attendant to regular employment, and

WHEREAS, Public management claims that contracting out represents a moneysaving alternative to in-house work in broad areas of service and support functions. These broad areas have historically covered transportation, maintenance, dietary, laundry and cleaning. There is now an additional thrust toward contracting out in such professional areas as data processing and engineering. Moreover, the health care field now sees the closure of hospitals and subsequent use of private facilities instead of public institutions, and

WHEREAS, Contracting out is presented as a savings to the taxpayers. In reality this is a false economy. There is no proof that private business contractors are more effective or less expensive than their government counterparts. Rather, there are hidden costs that do not show up immediately. Experience in the federal government demonstrates that costs of contracting out increase substantially in succeeding years and these increased contractual costs effectively eliminate projected savings, and

WHEREAS, Studies by government agencies and independent research centers are unable to show substantially better savings or effectiveness by contracting out. The City of Memphis announced that after studying the extension of private contract

refuse collection to a fringe neighborhood, it abandoned the idea because municipal refuse service was demonstrably cheaper, and

WHEREAS, Public employers must examine their present methods and then improve substandard management procedures so that costs can be cut and productivity raised. Such examination and improvement must be made before the contracting out of services is contemplated, and

WHEREAS, Productivity "improvement" cannot be converted into simple speed-ups or souped-up cost-effectiveness analyses. What is needed is a definition of productivity which places greater emphasis on the quality of services being delivered. This quality ideal should take into account a wide range of elements, including the distribution of public services. What this means is that "productivity" can and should be translated into good management. Beneficial change will come only when management deals with its own responsibilities, and

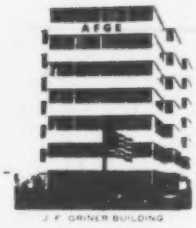
WHEREAS, Contracting out also has become a new form of political payoff and aggrandizement. We have only to look at the recent scandal where a former vice-president of the United States was accused of bribery in connection with contracting out of architectural and engineering services while serving as a county executive. In Albany, New York, a state inquiry into the city's contracting-out practices uncovered widespread corruption and deteriorating public services. Albany's reliance upon private contracts resulted in the waste of millions of dollars; therefore, be it

RESOLVED: That the AFL-CIO supports the principle that public work which has traditionally been performed by public employees should continue to be performed by public employees, and that public work which has traditionally been performed by private employees should continue to be performed by private employees; and be it further

RESOLVED: That the AFL-CIO continues to endorse and reaffirms its support of this policy.

The Committee recommends adoption of Resolution No. 119, and I so move.

. . . The recommendation of the Committee was adopted.



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STATEMENT OF

ARTE I. PIERCE
PRESIDENT, NATIONAL COUNCIL OF VA LOCALS
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

BEFORE

COMMITTEE ON VETERANS' AFFAIRS
U. S. HOUSE OF REPRESENTATIVES

ON

CONTRACTING OUT IN THE VETERANS ADMINISTRATION

OCTOBER 20, 1981

Mr. Chairman, members of the Committee. My name is Arte Pierce, and I am President of AFGE's National Council of VA Locals. We are the representative for some 110,000 employees in the Veterans Administration. I've been a VA employee for 32 years. I started in 1949 as a messenger, rated CPC-2 or otherwise known as "lower than GS-1." Becoming a file clerk was a promotion. Later, I was appointed file clerk supervisor--so I have spent time on the management side of the table, too. Eventually, I became an educational benefits specialist and then a claims examiner or adjudicator. After working as senior adjudicator, I became a GS-12 disability rating specialist which is the work I now do.

In these jobs I have dealt with veterans and the veterans service organizations on a daily basis. I can report that veterans share our concern at the adverse effects on contracting out of their medical and other benefits. As a long-time VA employee, I would like to make a few remarks on contracting out from the operational perspective.

The primary objective for the Veterans Administration and its employees is to render service to the veterans of the armed services. Neither the VA nor any of its employees benefit by skimping on service. The primary objective for any outside contractor, however, is to cut operating expenses in order to secure greater profits. We don't believe that care for veterans should be subjected to the pressure caused by a desire to boost profits.

The VA's own contracting out experience already demonstrates how scarce moneys can be taken from medical care. Medical laboratory tests have been contracted out by various medical centers. In Cincinnati, for example, the projected costs for contracting out laboratory tests was $160,000 for FY 1979. The Inspector General found that, even if the contractor's fees were lowered, the in-house cost would be $81,000 and ordered laboratory testing returned to in-house performance.

The intrusion of "profits" into the health care system will likely have other adverse effects besides the siphoning off of scarce funds. Since quality control is so loose in contracting out, contractors will have an interest in keeping their employees on minimum wages when possible. This would result in the VA contracts becoming an employer of transients who stay with the contractor only

until finding better employment. This would cause constant turnover and disrupt stability of vital VA operations.

I would hope that medical center directors and the service chiefs would have control over the contractor, but it is obvious that they would have no control over the contractor's employees. In fact, paragraph 6(d)(2) of A-76 specifically provides that the Circular "will not be used as authority to enter into contracts which establish a situation tantamount to an employer-employee relationship between the Government and individual contract personnel."

For VA patients, this removal of control over the workforce from the actual operating personnel can be quite serious. Hospitalized veterans on numerous occasions find it necessary to have their diets changed from one meal to the next. This can be readily accomplished at present with simple instructions from the attending physician to the dietician. A private contractor, however, is unlikely to have such a quick response time. Similarly, response time is critical in the event of any breakdown in hospital equipment during surgery or the need to institute immediate infectious control measures. We presently have in-house personnel who can meet these needs, but once contracting-out is underway, it is probable that the contractor will be unavailable for at least some of these "routine emergencies."

Much of the VA's experience with contracting out is with skilled trades--painter, electricians, plumbers and others. Often, the in-house personnel have to complete or do correctly the job which the VA contracted out. In 1979, the contract painters called in to the VAMC Denver, Colorado, partially completed the job and then left. It was necessary to use our own in-house painters to do the job.

In this case, the VA had made an advance payment to the contractor for work that they never completed. Similar problems occurred with the contracting out of other skilled trades at the Medical Centers in North Chicago, Marion, Illinois, Allen Park in Detroit, Ann Arbor, Michigan, Poplar Bluff, Missouri, and Danville, Illinois. It is hard to see how this experience justifies expanding the number of functions being contracted out.

I'm proud to say that I'm a veteran of World War II. I served in the U.S. Army for 35 months, 23 of them in the European theatre. Many VA employees are veterans. Whether in the regional office or on the hospital floor, we're proud to be a part of the "veterans caring for veterans" program. Medical center directors themselves fear the outside contractors will not display the same concern and sensitivity to veterans' needs as VA employees now routinely provide. As veterans ourselves, we share that fear. All we are asking is to be given the chance to continue doing the job. We appreciate the Committee's continuing concern and support for the Veterans Administration and we promise you our cooperation.

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STATEMENT OF

VIRGINIA O'DELL
PRESIDENT, AFGE LOCAL 2547
VETERANS ADMINISTRATION MEDICAL CENTER IOWA CITY, IOWA

ON

CONTRACTING OUT IN IOWA CITY, IOWA

OCTOBER 20, 1981

My name is Virginia O'Dell and I'm president of AFGE Local 2547 at the VA Medical Center in Iowa City, Iowa. I've been a nurse for 17 years, the last six of them in the VA. I work in "hospital based home care," which is one of the special health care programs of the VA. By treating patients in their homes, we eliminate unnecessary trips to the clinics and shorten hospital stays. This helps VA save money which it then uses on other medical care.

Most of the VA employees in Iowa City are veterans, and they include disabled veterans and several former POW's. They are proud of their jobs as the "veterans caring for veterans" program.

The single most important message I want to give this Committee is that we don't have to wait for contracting out to hurt the VA. A-76 and contracting out has already harmed the VA hospital system. I cannot tell you how often I'm asked by other VA employees whether they'll have a job next. "Virginia," they ask, "should I sell my

home because I won't be able to meet the payments if my job is contracted out." Others have saved money and are thinking of buying a house. They ask if they should buy.

Frankly, it angers us out in the field because we know how important our work is. We have the feeling that someone in OMB decided we were going to be contracted out, regardless of what it cost either in money to the VA or in care to the veteran.

Many of the VA patients have read about OMB's plan for contracting out in VA hospitals in their veterans service publications. The patients waver from being fearful to being furious.

I'm proud to say that I work in a VA hospital. From the first day on the job, VA employees learn that our job is to serve the veteran. Our rule is the patient comes first. And since many of the employees are also veterans, they know that they may be in the hospital one day. So they take extra care to see that they do indeed serve the veteran.

Frankly, its not the same with the contract employees we already have working in Iowa City.

We contracted out maintenance of our boiler plant and our chiller plant. Last spring the chiller plant just couldn't seem to get the air conditioning in the operating rooms right, and I was told that the contractor had put in the wrong refrigeration pipes and our in-house workers had to fix it. In 1979, the contractor's employees for the boiler plant caused a fire by welding in an area filled with coal dust. The fire spread through the mail shutes, and the fire trucks couldn't get to the fire because the contractor's vehicles blocked the fire lanes. Ten VA employees wound up in the medical intensive

care unit with severe smoke inhalation because they fought the fire.

As a nurse, I want to stress how important to patient care are the activities of a lot of workers whose jobs are targeted for contracting out. We had contract carpenters who worked in a surgery ward but didn't bother to put up dust barriers. You could see clouds of plaster dust in the air as you walked down the hall. They carted off the old plaster in open wheelbarrows, and patients, nurses, vistors, and volunteers had to walk through their spillage. Patients on that ward all had new surgery wounds, and many developed staph infections because of the dirt. In fact, surgery was suspended in the ward for a while. I'm not saying the contractor's employees did this on purpose. They were hired, by the contractor, to tear out a wall. But where was their concern for the VA patient? VA employees rarely are so shortsighted. The veteran comes first.

Our janitors are an important part of the health care team. When the janitors attend to all their duties--cleaning the rooms and furnishings, wiping up unexpected spills, and others--the nurse is available to provide patient care. If a contractor tries to make money by relying on a transient, minimum wage work force--I can guarantee the nurse will end up swinging mops instead of nursing patients.

As a nurse I also know the groundskeepers contribute directly to patient care. At Iowa City, we have 3 groundskeepers and about 20 patients who help them either in a voluntary or minimum wage capacity. Their work outside, whether planting flowers or trimming hedges, has a therapeutic value for these patients that you couldn't possibly measure in an OMB circular. Because the groundskeepers are veterans,

they make sure that the patients' work is as beneficial as possible. Can an outside contractor--whose goal is a higher profit--be relied on to do the same? Of course not. As a nurse though, I want you to know that you can see the difference in these patients when they are able to put in their work on the grounds.

Finally, I want to leave this Committee with two thoughts. As a nurse, I wonder who will be in the kitchen fixing the special diets or in the laundry cleaning the linen when the contract employees go on strike? Our contract employees in Iowa City have already engaged in strikes. Fortunately, we had enough VA employees who cared enough to spend extra hours getting the contractors' job done.

VA employees have never gone on strike--not even when we didn't get our paychecks last year because the appropriations bill hadn't passed.

My last thought is really a special plea. Congress has to do something so that VA employees--all Federal employees really--stop falling further behind everone else in pay. We got a 4.8% increase this year. Right across the street, the University of Iowa hospital employees got 8%. I don't believe their standard of care exceeds ours. For comparison, the municipal fire department got a 14.2% increase.

VA employees deserve a fair wage, just like everyone else. They do not deserve the stress and turmoil of wondering whether they're going to lose their jobs because someone behind a desk at OMB in Washington--who I would bet isn't even a veteran--decided that VA hospitals no longer need VA employees. We wonder if OMB's next decision will be that veterans no longer need VA hospitals.

I thank the Committe and would be pleased to answer any questions.

COMMENTS AND RECOMMENDATIONS ON OMB CIRCULAR NO. A-76
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES
JULY 1977

This paper constitues the views and recommendations of the American Federation of Government Employees on OMB Circular A-76. For convenience of reference these comments track the Circular by reference to its numbered paragraphs. They are directed at the substance of policy and set forth the principles AFGE feels should be observed in the revision of the Circular. These comments do not address specific language content, as it is assumed that once policy changes are determined, draft language will be published for comment by way of a rule making procedure under the Administrative Procedures Act. Our comments and recommendations are as follows:

I. Definition of the Problem

The purpose of A-76 should be refocused away from any notion that Government engages in commercial and industrial activities in competition with private enterprise. Rather, in the light of Watergate and its implications, and recent procurement scandals, A-76 should emphasize that the procurement process is totally subject to the mandates of the law. It should reflect the central tenet of representative government, namely that the government can do only what the law, i.e. the Constitution, and acts of Congress, empowers it to do. The derivative of this is that government officials can do only what the law expressly authorizes them to do. (The "Watergate" formulation was the reverse - "a government official can do anything not expressly prohibited by law".) This laxness in observance

of the mandates of law has permeated the procurement process, which in its fiscal accountability aspects presents a stark picture of chaos and lack of control when compared with the fiscal management of Government internal operations.

The pronouncement that the current study will adhere to the "principle" that "in a democratic system, government should not engage in competition with its citizens" accepts in part a major distortion upon which A-76 is erected. This distorted assumption leads to the erroneous premise that because the Government must employ large numbers of typists, it is therefore engaging in competition with businesses which sell typing services. In so doing the study orientation appears to be somewhat pre-set by the slanted orientation of A-76. Hence, we find it necessary to suggest that any revision of A-76 should begin by correcting the basic frame of reference within which the study is to take place, and the basic "purpose" orientation of the directive itself.

We start at the beginning-

Government is public.

Business is private.

Government is to serve the public interest.

Business is to serve private interests.

Government is non-profit.

Business is profit directed.

Government <u>per se</u> has no competition.

Business is competitive.

Government can only do what the law authorizes.

Business can generally do what the law does not prohibit.

Government, through acts of its officials and employees, exercises the sovereignty delegated to it by the people.

Private business has no such delegation and exercises no sovereignty.

The constitution provides for the methods of staffing the Government with principal authority given to the Congress.

Business is free to staff itself in any way the market place allows.

Government is basically a consumer of products, but a producer of services.

Business is basically a producer of both products and services.

To confuse the dichotomy between the character and function of private enterprise and of Government activity, disserves both Government and the private sector and therefore disserves the public interest.

The public interest is disserved because legitimate operations of Government which must be conducted by Federal employees are often made cost-inefficient, and the services provided ineffective, as a result of the contracting out policies forced upon operating managers by OMB. Appended to this statement are illustrative examples of internal agency memoranda showing the effects of one such policy, namely personnel ceilings.* These memoranda reflect agency management's desire to perform the work in-house which, because of arbitrary personnel ceilings, they were required to contract out. The services

* That such ceiling should be abolished is amply demonstrated by the June 2, 1977 Report of the Comptroller General, FPCD-76-88, entitled "Personnel Ceilings - a Barrier to Effective Manpower Management".

involved are ongoing Government requirements funded by the expenditure of tax dollars.

In the name of efficiency or cost savings, or personnel controls, agency managers are told they cannot manage their programs the way they deem most efficient. No private sector business could operate efficiently under such conditions nor can any Government agency.

Similarly, there are literally hundreds of essential Government activities conducted by Federal employees that are made cost inefficient as a result of procurement practices dictated by the distorted thrust of OMB Directive No. A-76. For example, a Government machine shop, fully capable of stamping out needed washers from available stock on hand, is required to go to a commercial procurement to obtain the washers at high overhead and much higher per unit cost. This is true although the production of the relatively few items of the type needed could be readily accommodated by the existing equipment and work force. In short, inefficiency is forced upon many Government operations by procurement policies stemming from OMB Directive A-76 and related funding and staffing ceilings imposed on agency salary and expense funds.

If cost efficiency and program effectiveness are major objectives of the Government, then the Government bureaucracy should be permitted to function as efficiently in the conduct of essential operations as the private sector, subject only to public interest type controls. In short, if an activity is properly performed in-house, then Government managers should be allowed the discretion to operate

efficiently free of misdirected procurement policies, artificial personnel ceilings, and grade controls. Once the level of the appropriation is set, the manager should be free to operate within that dollar amount using Federal employees, in the most efficient manner possible. Contracting out simply puts additional indirect employees on the Federal payroll and either removes them entirely from managerial control, or if not, creates an illegal employer-employee relationship between the contractor employees and the Government.

Our experience demonstrates the contracting out for services in most instances, does not save the Government money, does not improve the service, and tends to leave the remaining bureaucracy in a hobbled or decimated condition which causes its operations to become more inefficient and disjointed. Further, and just as importantly, it removes responsibility for the service from agency management to private hands, and thus diminishes the accountability of Federal officials to the public they are paid to serve.

The best macro example of this when an entire department was "contracted out" is the Postal Service. Postal rates soared and service declined. When the Postal Service was a Cabinet Department with close congressional oversight, such conditions as we are now experiencing would have been unthinkable. No congressman would dare vote to raise the first class postal rate or cut off deliveries without overwhelming evidence that no other alternative existed. The ballot box would have corrected matters rapidly. Now there is

a "corporation" with modern business management in charge and somehow, the responsiveness to the public and the capacity of the electorate to call the Postal Service to account has been grossly diminished. This week's press accounts note that the probable reason the Postmaster General proposed that the individual First Class mail rate not be raised to 18 cents along with the business First Class rate was to head off pressure on the Congress to put the Postal Service back under congressional control.

The same general pattern pertains when segments of an agency's support services are contracted out. The "low bidder" gets the work. The buy in, change order, renegotiations, cost adjustment techniques by which low bidders become high-cost service providers are well known and one might say accepted procurement practices. So unfortunately are cost overruns. Agency management, which may have opposed contracting out in the first place is now off the hook. If service fails, or the contractor defaults, or cost escalates agency management is not responsible. Neither is the procurement officer. He chose the lowest bidder in accordance with existing regulations. The procurement system thus insulates all officials from any real responsibility for what happens to the public interests involved in that particular agency's operations. Where competitive bid practices are not followed the scandals get worse. The Small Business set aside for minority enterprise recently exposed in hearings by Senator Chiles is symptomatic. Here again, the operating manager of Federal programs are off the hook. They are like the housewife who explains to an irate husband she did her

duty by calling the service man and paying his price. It is not her fault the trouble did not get repaired or that the work was shoddy.

The point is fundamental. Government procurement, involving billions of dollars, has a dynamic of its own. In many of its ramifications because of the ill conceived policy orientation of A-76, it impedes and detracts from efficient management of essential Government operations by responsible and accountable public employees and officers. We believe this issue deserves penetrating study and correction in any revision of A-76. Further, we believe the recommendations we make herein will substantially alleviate the problem.

The threshold issue is to determine what is, and what is not, essential governmental activity. Central to such a determination is the recognition that the Government acts both in a consumer and a producer role and the use of decisional criteria that discriminates between these two roles.

Relative cost has no materiality per se to this determination. For instance, clearly a contractor can be found who would be willing to administer the Food and Drug Act more cheaply than the Government. Just as clearly, there would be a loss of official control and accountability and an improper delegation of governmental authority and responsibility to private interests if this function were contracted out.

If the function is essentially governmental in nature, its performance costs is only a material consideration as to whether it should, or should not, be done and how much of it should be done. This is determined at the present time within the normal budget processes and should remain so.

In making the determination between Government and non-Government activity, the character of Government activity must be defined by function and type. That is, those activities that are inherently governmental in character and those that are not. Also, and just as important, a clear distinction must be drawn between the Government's use of products, i.e. its consumer role, and its provision of services to the people, i.e. its producer role. Activities which are inherently governmental cannot lawfully be contracted out under any circumstances.

They involve the exercise of sovereignty over the people. They include such activities as:

- law enforcement;
- regulation of commerce and industry;
- direct national defense and security functions;
- management and direction of the Armed Services;
- development and use of space, the oceans, navigable rivers and other natural resources;
- development and use of atomic energy;
- the conduct of foreign policy;

- intelligence and counter intelligence operations;
- the control and management of public lands;
- the collection and disbursement of revenues and taxes;
- control of the public treasury, accounts, and money supply; and,
- the administration of public trusts, such as the social security system, among others.

In the area of the national defense, space exploration and atomic energy, the delineation of what is an inherent governmental activity, and what is not, has been made unduly obscure and ill defined as a result of procurement policies pursued during the past two decades.

No one would seriously question the essentiality to our national defense of a strong industrial, technological base in the private sector. The Lockheed bail out, however, is an illustration of the shadowy nature of the interface that has developed between the military-industrial complex and Government. The revolving door by which high level management and technical personnel rotate between Government policy and management positions and employment by defense and space industries, presents serious conflicts of interests and ethical questions to say nothing of possible illegal relationships. Atomic energy presents still another facet of this industry-Government relationship where procurement practices disserve the public interest. The industrial-commercial spin off of atomic technology, developed and paid for by the taxes of the American people, is not the sole preserve of private enterprise. Neither is

space technology. There is a stark destinction between the entitlement and use made of discoveries, inventions, new systems, and new designs when developed in a Government laboratory or operations as opposed to developments by contract. Although many procurement contracts call for the Government to own inventions and discoveries made under contract, there is no effective control or effort to ensure that this is done. Indeed in many areas of advanced technology the Government lacks the expertise to make such determinations.

Yet we hear and read most about the essentiality of the so-called free competitive enterprise to roam these preserves unhampered by too much Government red tape and the inefficient Government bureaucracies which have responsibilities in these areas. Federal employees are painted as incompetent, lazy and overpaid, an image which is false and distorted and rebuttable by the facts of employee performance. Its the apparent lack of governmental competence to manage and control the essential public interest involved in atomic energy and space technologies that should be our direct concern. Our attention should be directed at the lack of an adequate "core of competence" of career Government employees, sufficient in numbers, and possessed of the skills, which would enable them to deal with these complex matters solely in the public interest.

Here again the dynamics of the procurement process and the policy orientation of A-76 has permitted the emasculation of such in-house competence where it once existed and has retarded or prevented its growth where required by new developments. The reason Admiral Rickover, for example, appears as a relatively lonely figure on this horizon is because there are indeed so few like him in the public service. He appears almost like a whistle-blower, but he simply professes honesty, accountability and due regard for the public interest.

Government research laboratories have been contracted out or dismantled in consonance with the policy thrust of A-76. This we believe to be clearly wrong, and clearly dangerous to the preservation of a free society. That such a policy thrust in an Executive Branch directive violates existing congressional policy mandates is clear. For example, in the Postal Service and Federal Employees Salary Act of 1962 (P.L. 87-793, the Congress declares that "the functions of a Federal salary system are to fix salary rates for the services rendered by Federal employees so as to make possible the employment of persons well qualified to conduct the Government's programs and to control the expenditures of public funds for personal services..." Congress further proclaimed that: "fulfillment of these functions is essential to the development and maintenance of maximum proficiency in the civilian service of the Government..." and it enacted into law the principle of comparable pay for comparable work between the public and private sectors so that the Government could attract and retain the necessary competence to perform its mission properly.

This congressional policy is sound. It has been seriously disregarded at great cost to the civil service at all levels by contracting out on the basis of comparative costs in accordance with the skewed cost analysis required by OMB Directive No. A-76. The impact of such misdirected contracting out is not limited to erosion of the core of competence. It affects all facets of the merit system and offends numerous congressional policies relating to Government personnel, ethics, conflicts of interest and integrity as explained in an analysis after an extensive study by the Civil Service Commission's General Counsel as early as 1967. I have appended a copy of that analysis to this statement for convenience of reference, which most significantly, is entitled "The Personnel Laws as an Expression of National Policy".

A-76 recognizes as beyond its scope in paragraph 4(a) those services which are provided directly to the people by Government. This is a proper exclusion and should be retained. If inherently governmental activities are for performance by Federal employees as are services provided directly to the public the real issue is which type and how much, if any, of the support type services which are integral to its inherently governmental activities or its production of services to the public can or should be done by private business enterprise as opposed to performance in-house by career Federal employees. This in turn, requires definition of who decides, and how. In short, a prescribed process of decision making.

II. A-76 Fails to Properly Define and Discriminate Between the Government and the Private Sector

The current A-76 deals with the dichotomy issue in paragraphs 1 "Purpose"; 3 "Definitions"; 4 "Scope"; and, 5 "Circumstances Under Which the Government may Provide a Commercial or Industrial Service for its own use".

The purpose paragraph accepts the assumption of Government/Industry competition, and formulates the issue as requiring a determination between whether the "commercial and industrial products and services used by Government are to be provided by private suppliers or the government itself..."

Paragraph 3(b) defines "commercial or industrial activity" (not "products or services") as providing "a product or service that is obtainable from a private source", but it excludes "a government-owned contractor-operated activity". (GOCO)

The problems with these definitions are manifold, namely they:

- confuse what the Government does to govern, or to provide services to the public with the means used to do so;
- equate "products" with "services";
- equate Government production with Government consumption.

Paragraphs 4 and 5 address the inherent governmental aspect of the problem more directly. They too, however, further skew the issue, and lack logical internal consistency. Paragraph 4 provides that A-76 will not be used:

- as authority to contract;

- to justify departure from laws or regulations, including regulations of the CSC;

- to avoid established salary or personnel limitations; or

- to alter the requirement that agencies perform for themselves "basic functions of management" essential to retain control over the conduct of their progams, including such functions as:

    - selection and direction of government employees;
    - assignment of organizational responsibilities;
    - planning of programs;
    - establishment of performance goals and priorities;
    - evaluation of performance.

Excluded from the scope are:

- management advisory services, including legal services;

- products or services provided to the public - (but not products and services used by agencies to serve the public);

- products or services obtained from other Federal agencies;

- any application inconsistent with a treaty or international obligation.

Paragraph 5 allows the Government to provide itself with commercial or industrial products or services where -

- commercial procurement would disrupt or materially delay an agency's program;

- self provision is necessary for purposes of combat support, individual or unit retraining of military personnel or to maintain or strengthen mobilization readiness;

- a satisfactory commercial source is not available or developable in time;

- the product or service is available from another Federal agency;

- commercial procurement will result in higher costs to the Government.

When carefully analyzed these paragraphs present what are patently inconsistent and illogical considerations of dubious relevance and materiality to the decisional issues presented. They confuse:

- the consumption of "products" with the producing of "services";

- tactical and strategical national defense needs (i.e. short and long range objectives);

- procurement objectives with maintenance of private sector production capacity for defense purposes;

- "program effectiveness" with "cost efficiency";

- "basic functions of management" with the essential character of inherently governmental activities;

- program administration with procurement administration;

- the mandates of law with the discretion of policy.

Some of these to be sure are essential considerations to determining what is and what is not an inherently governmental activity, however, they are not related to this or any other discreet issue with logical consistency or clarity of purpose in the current Directive.

III. The Principles by which Essential Government Functions should be Determined.

As a general proposition it can be said that there is very limited need for the Government to act as a producer of products it consumes except where relatively low level production is integral to the efficiency of an operation of which it is part. Hence, for the Government to engage in mining, manufacturing, construction, or agricultural activities to meet its product needs would place it in an unseemly competitive posture with private enterprise in these areas.

On the obverse side, it can be said that the central purpose of Government is to govern and to produce services to its citizens and that as a general proposition the former must be done by Federal employees and the latter should be done by Federal employees.

Consequently, if assumptions are to be employed as decisional guides, there should be an assumption against Government producing products which it consumes by using Federal employees and in favor of government producing services necessary to govern and to providing direct service to the public using Federal employees.

The resulting dichotomy would require a workable definition of "products" and of "services". At the present time A-76 in paragraph 4(d) properly excludes "products or services which are provided to the public" and this exclusion should be continued. Consequently, the issue resolves itself essentially to what may be called "support services", namely, those services the Government uses in order to govern and to provide services directly to the public.

"Product" may be defined as the physical object made by the direct application of human effort. "Service" may be defined as the system or method of providing people with the use of something including the application of individual effort which does not result in a product.

III.(a) Government Production of Products

The presumption here is against Government production. There are notable exceptions - namely:

- the production of currency, coins, certificates and other official documents which represent the fiscal obligations of the Government;
- the development and production of atomic energy and related technology;
- the making of products incidental to research and development efforts required in the national interest;
- the building of dams, roads, and harbors, on public lands and waterways to maintain a productive capacity in the Corp of Engineers for national defense purposes;
- minor type production of needed products where the production is integral to the efficiency or effectiveness of the operation of which it is a part. An example, would be the production of washers or brackets by a Government machine shop as an integral part of machine shop operations;

The decisional criteria here should be that:

- no production shall be done by the Government except as required:
  - to maintain national defense capability;
  - to protect the integrity of official government monetary and fiscal issuances; and
  - to maintain the efficiency of low level internal operations of which the production is an integral part.

The process for decision, except where expressly authorized by statute, should require certification by the head of the agency that such production work is required to be performed in-house. The justification would be handled as part of the normal budget process of the agency and approved or disapproved, and funded at whatever level was determined in the annual budget formulation process. There should be no authorization outside of the normal budget channels.

III. (b) The Production of Services

Here the presumption would be in favor of the Government producing those support services necessary for its inherently governmental functions and the provision of services to the public.

The decisional criteria which must be considered in determining the propriety of contracting out for any such services are as follows:

(a) compatibility with the maintenance of internal agency capacity to perform its in-house functions effectively and efficiently, including national security considerations and the integrity of the function supported;

(b) compatibility with Government control and accountability for the total function supported;

(c) compliance with:

- the civil service laws and policies
- wage and salary laws and policies
- fair employment policies and practices;

(d) budgeted costs are no higher than budgeted in-house costs for comparable service.

We do not believe the separate procurement oriented system of administrative reviews and cost comparisons required by A-76 is justified or desirable. First off, it increases administrative costs. But more importantly, it isolates the decisional process from encompassing the necessary trade off values, and has totally failed to result in any sensible form of accounting or recording of service contractor effort. No one knows the total scope or cost of such activity today.

In lieu of the present A-76 cost comparison and review system, we strongly urge that the decisional process by which agencies determine to contract out for services be fully integrated into the normal agency budget processes. In final analysis what is involved is indirect staffing of the agencies by use of service contract personnel. Integration into the budget process would eliminate the special comparative cost analysis now required by A-76 and would ensure more thorough consideration of the trade off values inherent in the recommended criteria. The process would be as follows:

Each function which is proposed to be contracted out in the next budget year would be identified and justified in accordance with the above criteria within the agency budget formulation process. Each aspect would be considered and costed out using the ordinary budget and accounting methodology of the agency. The cost and the number of funded man years involved would be set forth as determined pursuant to Invitations for Bids or quotations issued by the agencies for that purpose. These requests would be submitted to OMB in the same manner and with the same justification as agency salary and expense budgets.

The OMB decisional process would be the same as it is with respect to career employee staffing requests with one exception - that is any proposal involving the displacement of civil service career personnel would require the approval by the Civil Service Commission and a determination that it would not adversely impact upon the operations or the objectives of the career personnel systems of Government.

With the exception noted, both the number of funded man years and the cost for each activity would be authorized and approved as part of the agency budget submission. The President's budget as transmitted to the Congress would contain a separate analysis of the procurement of services by contract showing the agency, the function, man year levels and costs for each agency. A separate break out of the total service contract effort would be included in the Special Analysis which is issued with the macro budget.

Contracting out would become authorized only to the extent Congress enacts appropriations therefore. If the activity involved requires authorization the regular authorization procedure for new programs would be followed both by the Executive Branch and the Congress. Each year's budget justification would be required to contain a report on the last procurement as to contractor performance, cost effectiveness and efficiency as well as continued compliance with the decisional criteria. Such a report and accounting would be required on all service procurement whether or not they are proposed for continuation.

Such a procedure would tend to ensure that the following considerations are observed:

1. The propriety of contracting out versus in-house operations under the decisional criteria noted above, with appropriate trade off decisions made by agency management responsible for the efficient operations of the total agency.

2. Control of costs and man year levels of effort.

3. Accounting for costs and man year effort on a uniform consistent basis throughout the Executive Branch.

4. Proper evaluation of contractor performance.

Other benefits would be:

- the yearly review of such operations within an existing administrative system in accordance with the same zero based budgeting concepts applicable to in-house operations;

- a two year period of advance notice to Federal employees and to the private sector of the projected need for services by contract and the dollar amounts and level of effort involved;

- a uniform accounting and control method which would for the first time bring such activity under overall administrative control;

- a system of recorded data, including type of functions, levels of effort, and costs for each agency of Government and the Government as a whole.

Application of the Proposed Cost Criteria (III b(d) above)

If the trade off decisions are made in accordance with the suggested criteria, giving due consideration to the observance of established Federal wage and salary laws and policies, most of the cost manipulation which unions find objectionable would disappear. For example, adherence to this criteria would administratively eliminate the difference in protection accorded contractor employee negotiated rates and fringes and that afforded Federal wages and salaries where the work is being proposed for contracting out in the first instance. Federal employees and their unions should be given the same wage cutting protection extended to contractor employees and their unions. Bidding between in-house and out-of-house should follow the same rule regarding wages and fringes that is observed when out-of-house work is bid for between successive contractors. Executive Branch policy should require this.

Further, we believe that budgeted costs should be used for the cost comparisons as they show the nearest actual incremental costs that will be incurred. Here again the costs are those that are actually budgeted. The contractor costs are thus controlled. If they are budgeted above what the in-house costs are, the work stays in-house. If they are less, the work may be contracted at the lesser figure and its continuation justified on yearly evaluations within the budget process. But the budget would control the contractor's take. This should help control the "low bid-buy in" abuses that have grown up. It should also help control the "change order" system of contract cost escalation.

As to elements of comparable costs, we believe only incremental costs should be used for cost comparison purposes. That is to say, no incremental overhead for administrative personnel would be added to in-house costs where the contracting out would not result in a reduction of administrative personnel. Conversely, such a charge to in-house cost would be made where it would result in a reduction of such personnel.

The same principle of incremental costing would apply to all costing determinations, and would become the basis for actual budget requests. All so called "common costs" would wash out and be disregarded. Hence, we recommend going solely to incremental costs within the budget process and eliminating common costs from the comparison altogether. "Common costs" are those which remain unchanged under either alternative. "Incremental costs" are the future costs that are different depending upon the alternative chosen, i.e. in-house or contract. This same costing methodology (but not integrated in the budget process as we propose) was recommended by the House Committee on Government Operations, after extensive hearings in 1968. (See criteria for support service cost comparison, Thirty-Seventh Annual Report of the Committee on Government Operations, 9th Congress, 2nd Session, House Report No. 1850, August 5, 1968).

One further matter on costing deserves critical analysis. To have comparative costing the exact service performed in-house and being proposed for contracting out must be stated in precise and

accountable terms, using man years of effort, elements of service (e.g. meals served), or other measures of quantity and quality, (e.g. square footage cleaned, and waxed to a prescribed standard). The process of analyzing needs and defining services required would be better accomplished in the context of total agency Zero Based Budgeting than in any other system known to us.

The need for accounting is met by the budget process and is justified by the magnitude of the expenditure involved.

Within DOD in 1976 support service contractors provided 26% of the manpower to perform work coming within the purview of A-76. This amounted to 97,250 civilian man years of effort.

These man year estimates are apparently not complete or accurate, and comparable figures from other agencies and departments are not available. However, one thing is clear - expenditures of this magnitude for what amounts to indirect-hire Federal employees should be brought under complete budget and accounting control if tax dollars are not to be squandered. Our recommendation is to do just that - integrate the procurement of such services and the decisions relating thereto, into the normal budget process.

We believe the recommendations here to be sound and in the best interest of the Government. We believe, if adopted, they will add to the proficiency with which Government operates, and restore balance and equity to the procurement process. We do not equate Government service with private enterprise, nor do we view Government service as a fat preserve to be divided up among profit seekers. A balance of values is required and we believe it can be achieved by the changes we recommend.

88-005 O—82——14

UNITED STATES OF AMERICA
GENERAL SERVICES ADMINISTRATION
WASHINGTON, DC 20405

JUN 29 1976

Honorable J. Glenn Beall, Jr.
United States Senate
Washington, DC 20510

Dear Senator Beall:

This is in response to your letter of June 11, 1976, on behalf of Mr. Albert M. Kavanagh questioning General Services Administration's (GSA) determining and affectuating its workload requirements.

Mr. Kavanagh is incorrect in stating that "personnel ceilings for wage grade custodial and crafts in the past have been established by means of management surveys of buildings and equipment." Overall employment ceilings, as we indicated in our letter to your office dated May 19, 1976, are established by the Office of Management & Budget. We manage our resources within the ceiling and budgetary restrictions imposed by the Office of Management & Budget and the Congress. Workload requirements are determined by survey and the application of standards. The two terms, "personnel ceilings" and "workload requirements", are not synonymous. Though the ceiling on our work force has been reduced; the workload of operating and maintaining space for Government agencies continues to increase. Therefore, the workload for which we do not have ceiling, is accomplished by contract.

Regarding Mr. Kavanagh's reference in the last paragraph, the agency has already provided the cost analysis, financial data, cost comparison, etc., required by the agency in the performance of contracting out its work. This material was supplied to Mr. Elder H. Phonicie, President, American Federation of Government Employees (AFGE), Council of Locals 1497 & 2165, in a letter dated May 14, 1976, (copy enclosed) as a response to a Freedom of Information Act Request concerning the contracting out of work in several locations in the Baltimore Area. We believe our previous correspondence with Mr. Kavanagh was responsive to this issue.

I trust this information is of assistance to you.

Sincerely,

TERRY CHUMBRS
Deputy Administrator

Enclosure

Keep Freedom in Your Future With U.S. Savings ATTACHMENT I

COMMANDER

NAVAL EDUCATION AND TRAINING CENTER

NEWPORT, RHODE ISLAND 02840

9 OCT 1975

Mr. Thomas Smith, Acting President
American Federation of Government Employees
Local No. 190
Naval Education and Training Center
Newport, Rhode Island 02840

Dear Mr. Smith:

This will reply to your letter of 25 September 1975 concerning the disestablishment and contracting out of the janitorial services at the Center. Recognizing your rightful concern for the employees you represent, the following information you seek, to the extent presently available, is furnished. Each response is keyed to the corresponding paragraph and sub-paragraph of your letter.

1. A copy of the Invitation for Bid and contract specifications will be furnished when they are completed.

2. This information will be provided to you when it is available. It is expected to be available immediately after bid opening.

3. A copy of the letter of award will be provided to you when award is made.

4(a). No correspondence of this type has been exchanged at this time.

4(b). A wage rate certification has been requested from the Department of Labor. A copy of their reply will be provided to you when it is received.

4(c). No correspondence of this type has been exchanged at this time.

5. A copy of the contract will be provided to you at the time of award. All pertinent cost and financial data will be a part of that contract.

6. OMB Circular A-76 requires that a cost analysis be performed only when the justification for contracting out is cost savings. The decision for contracting out all the janitorial function at the Naval Education and Training Center Newport was not cost savings but rather a reduction in civilian personnel ceiling directed by higher authority. Consequently, a cost analysis is not required. However, in accordance with normal operating procedure, a Commercial/Industrial (C/I) study, comparing the costs of in-house versus contracting out the janitorial function, was in progress at the time of the directed reduction in ceiling. A copy of this C/I study will be provided to you when it is complete.

7. CNET NOTICE 4860 dated 13 August 1975 and CNTECHTRA letter dated 5 September 1975 are provided.

8. The information requested is attached. The future effect of contracting out the janitorial services is the complete elimination of the Janitorial Branch within the ACSO for Facilities Management organization.

9. The statutory authority for accomplishing janitorial services by contract is set forth in Chapter 137, Title 10 of the United States Code and promulgated to the Commanding Officer by the Armed Services Procurement Regulation (ASPR); NAVFAC P-68, Contracting Manual; and other Navy procurement directives.

10. The contract will be a small business set-aside as required by ASPR 1-706 and NORTHNAVFACENGCOM INSTRUCTION 4380.1 as follows:

a. ASPR Section I, Part 7 provides that every proposed procurement in excess of $2,500, but under $500,000, shall be considered as having been designated as set-aside for small business.

b. NORTHNAVFACENGCOM INSTRUCTION 4380.1, paragraph 4.a.(2) states that all construction and maintenance service contracts, $2,500 to $500,000, shall be considered as automatically set-aside for small business.

11(a) through 11(f). No information.

11(g). The contract performance specifications are included as a part of the Invitation for Bids to be furnished in response to 1. above. Should any information be received relating to the adequacy of these standards of performance, it will be furnished to you.

11(h). Any information of this type which is available concerning the successful bidder will be furnished to you when the successful bidder is known.

11(i). Means and methods to correct or improve contractor performance are included as a part of the contract specifications to be furnished in response to 1. above.

11(j). It is acknowledged that the contracting out of this function is prejudicial to overall employee morale. However, the action was taken in response to directives from higher command. In general, with the elimination of the janitorial function, prospects for career advancement for the employees concerned will, of course, cease as will any benefits and rights accruing as a result of their Federal Employment. However, at least two are eligible for Optional Retirement; one is eligible for retirement based on involuntary separation; and approximately five retired military could retire by waiving their Navy service and combining it with civilian service as the basis for retirement. Employees who will actually be separated will be placed on reemployment priority lists and DOD Stopper Lists for consideration for reemployment in the future, if they so desire. Also, where eligible, Severance Pay and Unemployment Compensation benefits would also apply.

11(k). The contract specifications to be provided in response to 1. above cover this point.

11(l). No information. This has not occurred in any previous service contracts awarded by this Command.

11(m). The General Provisions of the contract to be provided to you have specific restrictions which cover potential conflicts of interest.

11(n). No information. Specific performance standards are required in the contract specifications. The manpower assigned to these performance requirements are the sole responsibility of the contractor. However, in reaching the government cost estimate of the fair value of the services to be provided, an estimate of the required manpower is made. This cost estimate is kept confidential until the bid opening. A copy of this estimate will be furnished to you after the bid opening.

11(o). No Civil Service employees will assist in the accomplishment of the contract. However, it is expected that a position of Quality Assurance Inspector will be added to the NETC Facilities Management Maintenance Control Department. The function of this position will be to ensure the contractor's compliance with the contract's contractural performance standards. It is to be emphasized that no Civil Service employees will assist or supervise the contractor's work--only inspect it.

In summary, let me again reiterate that the action contemplated is the result of a reduction in civilian ceiling and does not in any way reflect on the loyalty, performance and dedication of the employees involved. This action, as with any action that adversely affects employees, is taken with reluctance and sincere regret. As noted above, and in keeping with the positive and constructive relationship that has consistently existed between your organization and the Center, when the data you requested becomes available, it will be provided to you. If I can be of any further assistance, please do not hesitate to contact me.

Sincerely,

H. R. [illegible]

Enclosures

MEMORANDUM FOR: CSF COL ANDERSON

SUBJECT: Contracting for Selected AFLC Support Activities

1. Mr Phil Dickey (DPQ) presented a briefing to the Commander concerning the results of Ad Hoc Committee findings on contracting in HQ AFLC. The following personnel were present:

General Rogers	CC
General Rhodes	CV
General Easson	DP
Colonel Morin	DA
Mr Dickey	DPQ
Mr Mandrell	XRS
Mr Niemier	PPP
Mr Jacobs	DPQ
Mr Fricsons	DAX
Mr Smith	DPC

2. The Ad Hoc Committee was established to identify potential contract candidates as a means of accommodating increasing budgetary pressures and constraints upon manpower resources. The Committee's charter was to evaluate Tiger Team III findings, develop a long range plan for contracting in HQ AFLC, follow progress of DOD initiatives to contract for total BOS functions at several bases, and consider alternatives to contract savings through organic manpower and organizational adjustments.

Members of the Ad Hoc Committee are:

Mr Dickey	DPQ (Chairman)
Mr Mandrell	XRS
Mr Niemier	PPP

Mr Jacobs DPQ

Mr Smith DPC

3. The following recommendations were made:

a. Contract Base Operating Support (BOS) at SM-ALC as a part of the DOD program outlined in General Hill's letter, 22 April 1975, (approximately 2000 spaces).

b. OO-ALC has developed studies of organizational realignments to save manpower. OO-ALC should be requested to update their studies and brief their recommendations to the Commander.

c. Contract the total mission of MASDC (approximately 950 spaces).

d. In addition to SM-ALC and MASDC initiate studies under AFR 26-12 for contracting specific functions across the Command (Atch 1).

e. Establish an overall master plan for the program with specific annexes (programming plans) for each major project. Abolish the Ad Hoc Committee and transfer overall responsibility to the new XR Directorate of Programs.

4. Discussion:

a. The briefing pointed out that due to the loss of over 44,000 spaces since FY 68 without commensurate workload reduction, an erosion of our mission and surge capability has become evident. The reductions in FY 76 will test the capability of the command to respond to the vital logistics responsibilities of HQ AFLC. All indicators point to even more drastic manpower and dollar losses in FY 77. Contracting provides an opportunity to save authorized manpower and ceiling by contracting low risk functions with a high return in saved spaces. The command can offset reductions imposed by higher headquarters and Congress and thereby protect the mission elements and surge capability. Contracting should emphasize cost advantage where possible but the basic reason for contracting is to assure mission accomplishment and surge capability. There is a problem involved in the use of manpower spaces saved by contract. Civilian manpower spaces are closely tied to dollars. In normal AFR 26-12 actions manpower spaces saved by contract are returned

to the Air Staff where the civilian pay represented is converted to contract money to pay the resulting contract. When Congress cuts civilian ceilings they also cut dollars represented by the ceiling loss. Program budget decisions cut manpower spaces, manyears and dollars. If HQ AFLC keeps the civilian spaces and dollars a requirement will exist for money to pay the contractor. It is assumed the Air Staff will be reluctant to accept this philosophy. The Commander agreed that a problem exists in this regard but stated that we as well as the Air Staff must reexamine traditional concepts in the light of existing circumstances.

b. A proposal was made to direct the establishment of Word Processing Centers and Administrative Clusters in HQ AFLC to achieve an FY 76 savings of approximately 100 manpower spaces.

(1) This proposal would establish Word Processing in HQ AFLC organically in FY 76 to achieve manpower savings. (A contract could not be awarded in FY 76 due to the time involved in the contract cycle.)

(2) Following organic establishment, the AFR 26-12 process would be implemented for contracting in FY 77/78.

(3) The establishment of the Word Processing concept in the field was also discussed. The Commander and Vice Commander agreed that we should move out on the concept and the discussion centered around whether we should go organic first with contract to come later. Colonel Morin was asked his opinion and stated that he believed a smoother transition could be made to contract if the new concept was first proved out organically.

c. In discussing the contracting of computer operations, General Rhodes remarked on the critical nature of our logistics information system and stressed that a rapid response work-around would be essential in the event of a contractor strike. General Rogers agreed but indicated that we must not arbitrarily dismiss any area from consideration for contracting. After considerable discussion on strike possibilities it was agreed that many low risk areas were available for contract and that it would be unnecessary to concern ourselves with the higher risk areas.

d. In 1973, CO-ALC performed a comprehensive study of reorganization options within the ALC and base support structures. The proposals of the Ogden study show the possibility of significant manpower savings through non-standard organizational alignments. General Rhodes remarked that he had examined the study and felt that some of the proposals should be more carefully examined for possible implementation.

e. One of the contract candidates proposed was to make one package of the Distribution function of on-base delivery, the DA function of mail and message delivery, and the MA function of Intra-Maintenance transportation. It was pointed out that these functions were homogeneous in that they utilize vehicles and people to move things from one place to another. During the discussion of this candidate the functions performed by DS and MA in their individual areas which are homogeneous to the Civil Engineering functions were examined. The Commander stated that these areas as well as other areas of the same character should be identified and closely examined to determine if manpower savings could be made by placing them under a single manager.

5. Directed Actions:

a. The Commander approved in principal the contracting of BOS at SM-ALC, the total MASDC mission, total PMEL function, and the development of the Word Processing concept in HQ AFLC and the field, first organically, followed by contracting if feasible. Word Processing in HQ AFLC is to be implemented immediately and at least 100 spaces saved to apply against the FY 76 headquarters reduction. Word Processing in the field is to be implemented as rapidly as possible but in accordance with a programming plan to be developed by DA.

b. DP will prepare a letter to the Chief outlining the actions directed and requesting policy clearance for the BOS and MASDC contracts. The letter will state that we will move ahead with the PMEL contract and the Word Processing development. The letter will also announce the organizational test at OO-ALC and request waiver of standard organizational structures directed in AFR 26-2. The letter will be available for the Commander's signature on 8 December.

c. DP will prepare a letter to the Commander, OO-ALC, requesting that he update the 1973 organization study and present proposals to the Commander.

d. The Ad Hoc Committee is abolished and XR is appointed program manager for all actions directed in 5.a., above. Immediate action should be taken by XR to determine progress already made in Word Processing and the contracting of PMEL. Upon receipt of a reply from the Chief, XR should have developed a master plan to encompass the total program.

P. S. DICKEY
Chairman, Ad Hoc Committee
on Contracting

4 Atch
1. Candidates for Contrac
2. Base Impact
3. Contract Milestones
4. Word Processing Statu

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THE PERSONNEL LAWS AS AN EXPRESSION OF NATIONAL POLICY

"All officers of the government, from the highest to the lowest, are creatures of the law and are bound to obey it.
"It is the only supreme power in our system of government, and every man who by accepting office participates in its functions is only the more strongly bound to submit to that supremacy, and to observe the limitations which it imposes upon the exercise of the authority which it gives." United States v. Lee, 106 U.S. 196, 220, 1 S.Ct. 240, 27 L.Ed. 171 (1882)

"No department of the government has any other powers than those thus delegated to it by the people." Hepburn v. Griswold, 75 U.S. (8 Wall.) 603, (1869).

In a government of delegated powers, where public office is a public trust, the authority to discharge official responsibilities reposes only in those persons duly appointed and vested by law with an office or employment. It is axiomatic that official authority can be delegated only to those properly appointed to exercise it. The Federal civilian service of the executive branch is in this aspect the personification of government by law; it is through the exercise of the powers of public office by Federal employees that the process of self-government is executed. The personnel systems prescribed by Congressional and Presidential authority constitute the exclusive methods of staffing this civilian service; of investing private persons with public authority.

The power to create Federal positions outside the civil service and personnel laws cannot therefore be implied; it exists only if expressly provided by the Congress. For a properly appointed official to create a relationship that by law must be regarded as an employer-employee relationship, in derogation of the laws and regulations controlling Federal employment is ultra vires. To the extent the exercise of official authority and responsibility is in actual practice delegated through such acts to private persons or corporations, there is an unlawful delegation or an abdication. To the extent such acts contravene the specific requirements of the civil service laws they are illegal.

Consistent with the genius of our government, the personnel and related statutes embody certain essential principles which must be observed if our concept of democracy is to be preserved.

Without express statutory authority a government agency cannot accept donated services from an individual, even if freely given.1/ A contrary rule of law would contain the seeds of tyranny and chicanery. Conversely, a Federal employee cannot accept any supplementation of salary from private interests.2/ To permit this would be to compromise integrity. A Federal employee cannot perform any service other than that for which his salary is appropriated by the Congress. To allow otherwise would permit unauthorized expenditures of public funds and confound accountability.3/

Consistent with the notion that ours is a government of the people and by the people, the opportunity to gain public employment must be open to all -- without regard to race, religion, color, national origin or political affiliation.

Consistent with the notion of a government for the people, only those whose character, fitness, and loyalty[4] are considered worthy of a public trust are deemed suitable, and only those willing to accept, under oath,[5] the responsibilities of public service are appointed. Limitations imposed by law upon the individual's right to strike,[6] political activity,[7] and conflicting interests[8] are strict but essential appurtenances to public office.

The classification law requires that governmental duties and responsibilities be identified and grouped into discrete positions, that positions be classified and that compensation be allotted on the principle of equal pay for equal work. The entitlement to a certain level of pay, to employee benefits, the evaluation of employee performance, accountability for public funds, government liability to third parties, employer-employee rights and obligations, and the ultimate legality of official acts are all affected by compliance or lack of compliance with the civil service and personnel laws.[9]

In addition, certain national policies of inherent social value are prescribed in the personnel laws. That honorable service in the armed forces of the United States deserves recognition through veterans preference is one such policy.[10] Nondiscrimination on the basis of race, creed, color, sex, national origin,[11] or politics[12] is another. Official recognition and dealing with employee organizations conditioned upon a no-strike pledge is another.[13] And economic security through retirement annuities for service or disability[14] is yet another.

It is these principles and policies that are disserved when personnel are unlawfully procured by means of contract to perform duties under circumstances that must under law be regarded as creating an employer-employee relationship with the government. This is particularly acute where the contractor supplies personnel who work on government premises, use government equipment, and are interspersed with and directed by civil service employees. There is, in such situations, an "interface" between the contractor's personnel system and all facets of the civil service system which is abrasive to employee morale, erosive of civil service laws and policies and destructive of efficiency and sound management.

For example, the government and private employer alike know the evils of nepotism, personal favoritism, and patronage, and the perils of incompetence. The civil service system has met this problem with the competitive examining process. This process has stood the test of time and has been effective for a myriad of occupations in all types of labor markets. A civil service examination rating is accepted as evidence of competence by private and public employers alike.

Contractors may also examine their job applicants but the quality of such examinations vary widely. Some of the contracts we have examined call

for personnel "competent to perform the work," or for "qualified" personnel. Standing alone, such standards are not especially meaningful. Where qualification standards are prescribed in contracts we find they are invariably civil service standards, sometimes slightly modified for the occasion. In our review of operations under contracts over the past two years, we often find in occupation after occupation, where both civil service and contractor employees are involved, that the assignments given civil service employees are the more responsible and difficult and require the greater skill.

In the matter of pay, such as incremental increases for superior performance,15/ time in grade,16/ and promotion practices, the use of contractor personnel sets up countervailing forces at the work site that derogate civil service objectives. Federal pay rates in the General Schedule are predicated on position classification principles. They are interrelated to provide orderly progression from one grade to another and designed to provide in-grade increases for performance at a satisfactory level of competence for periods of one year or longer.17/ Although comparable pay with the private sector is the policy,18/ Congressional action in prescribing General Schedule rates has resulted in compression at the higher levels, so that pay in the lower grades is comparable, and pay in the higher grades lower, than for private enterprise. Cash incentives are awarded only for special individual or group achievements.19/ A minimum of one year must be served in grade before a regular promotion can be made to a higher grade.20/ Wage board employees' rates are set at levels equal to average prevailing rates for the same level of skills in private industry in the area involved.21/ A wage board employee must be hired and compensated at established rates.

These compensation requirements of the public service do not necessarily bind the private contractor's pay, bonus, or promotion policies. For essentially the same work, performed under the same conditions, for the same government, a contractor and civil service employee of comparable skill and proficiency may be compensated and promoted at substantially disparate rates. Both, however, are paid by the government, one directly, the other indirectly.

Overtime work and pay levels are also prescribed by law for the civil servant,22/ but subject only to individual contractor policies for the contractor employee. These on-the-job conditions lead to justifiable as well as fancied reasons for employee dissatisfaction. The disadvantage from the civil servant's perspective is often apparent. Where this is so, morale is depressed, motivation is dulled, performance is affected, and in the end the ability of the civil service to function efficiently and effectively is diminished.

Another adverse ramification of these disparities is that the government is in reality generating its own competition for scarce skills. The

esoterics of space science and technology, for example, are the results of a national commitment to explore space. There is but one ultimate consumer and one ultimate beneficiary of this effort -- the public.

For the government to bid for shortage category personnel against personal service contractors is highly obstructive to the civil service system and contrary to sound manpower utilization practices. It is apparent in many cases that the contractor employees who possess these scarce skills are employed, or become subcontractors to the contractor, solely for the purpose of having their services sold to the government. In these situations, the contractor who provides solely personal services is actually substituted by a contracting officer for the civil service system. The net effect, as has been established by General Accounting Office audits, may well be higher cost to the government for services which should have been, and could have been, provided by regularly appointed Federal employees.

These comparisons, founded upon our investigations of contracting practices at several government agencies, can be shown with the same adverse impact upon the civil service system across the broad spectrum of personnel administration. There are similar disparities between the civil service and contractor employees in the entitlement to, and use of, leave for vacation,[23/] sickness,[24/] military service,[25/] jury duty,[26/] voting,[27/] blood donation, and family deaths; in compensation for on-the-job injuries[28/]; in retirement benefits for disability and old age[29/]; in group life[30/] and health insurance benefits[31/]; in travel and relocation allowances[32/]; in training and development opportunities[33/]; and in the rights and entitlements to inventions, patents, and the use of new technology[33a/], among others.

The extent of these disparities is magnified by the obligations imposed by law and regulation upon the Federal employee. Unlike his counterpart employed by a contractor, the civil servant must proclaim his loyalty to our constitutional form of government,[34/] under oath. His conduct is circumscribed by strict rules of ethics, prescribed by Executive orders[35/] and Congressional resolution[36/] and special provisions of the civil and criminal laws relating to bribery,[37/] graft,[38/] conflicts of interest,[39/] partisan political activity and fund raising,[40/] misuse or destruction of government property and records,[41/] habitual use of intoxicants,[42/] agency for a foreign principal,[43/] and the right to strike,[44/] among others.

We must also consider the impact upon employee loyalty. An employee's loyalty to his employer, be it government or private enterprise, is essential for efficiency of operations and for protection of the employer's interests. One surmises from our investigations that some contractor

employees are sorely perplexed as to where their loyalties should lie -- with the original contractor who hired them, the successor contractor that presently pays them, the future contractor that may hire or fire them, or the civil service supervisor in the unit in which they serve.

Civil service training, career development and merit promotion programs are incentives to motivate the employee to improve his skills, to enlarge his capabilities, and to adopt a public service career. These programs are mutually beneficial; the employee gains new capabilities and the government benefits by the retention of a skilled and experienced career civil servant. The training of contractor employees on the other hand is often at government request and either directly or indirectly at government expense. The government is not assured, however, of any continuing benefit from this investment.

Closely related to employee loyalty and morale is the matter of performance evaluation. Performance evaluation at best is a difficult, sensitive undertaking; however, where civil service and contractor employees are intermixed on the job, it becomes exceedingly difficult, if not impossible. This is particularly true where a contractor employee may be replaced by a civil service employee, or vice versa, on a particular task assignment prior to its completion.

As to on-the-job performance of the contractor employee, government managers have advised in the past that they could get an unsatisfactory contractor employee off the job in 24 hours. However, we are cited one example where separation was delayed three months and accomplished through the quarterly evaluation for determination of the incentive award fee. Presumably at this point, the contractor was informed that the "end product" e.g., the employee's services, were unsatisfactory.

Lastly, the furtherance of national policies through the civil service system may be compromised by unauthorized contracts for personal services. For example, in the Veterans Preference Act, now codified in title 5, United States Code, Congress has provided an absolute preference to veterans for positions of guards, elevator operators and custodians in the competitive service as long as preference eligibles are available.[45/] And what of the policy objectives served by the statutory restrictions on partisan political activity by Federal employees and the prohibitions against the right to strike? By what authority does an administrative officer, perhaps even a minor one, decide in the course of contracting for personal services that veterans shall not be accorded preference for custodial jobs; or that what is tantamount to Federal employee status can be conferred without the concurrent obligations to refrain from exercising the right to strike, or to avoid pernicious political activity?

There is clear recognition of the national policy embodied in the personnel laws in BOB Directive A-76, which prescribes contracting policy for the executive branch. This policy directive explicitly negates any intent to alter existing authorities, or to justify departure from any law or regulation of the Civil Service Commission, or to avoid established salary or personnel limitations. Contracts for personal services which in fact and in law do depart from civil service laws and regulations, are accordingly in violation of this policy.

That an agency or management official may consider the requirements of the civil service laws and policies difficult or tedious in application is no justification for turning the hiring and management of personnel over to a contractor.

The foregoing findings and conclusions have been distilled from Commission experience and constitute the basis of the Commission's concern in the matter of contract practices. There is no intent or purpose to reflect adversely upon the performance or capability of any contractor or upon the unparalleled contribution of private enterprise to government programs.

It is, however, considered necessary for the full discharge of the Civil Service Commission's duties and responsibilities as the central staff agency for civilian personnel, to clarify and amplify the legal, policy, and factual basis upon which contracts for personal services are proscribed under the national policy expressed in the civil service laws.

FOOTNOTES

1. R.S. 3679 (1875), 31 U.S.C. 665(b)

2. 18 U.S.C. 209

3. Art. 1, sec. 9, cl. 7, U.S. Constitution, R.S. 3678 (1875), 31 U.S.C. 82(c),628. Cf. Converse v. United States, 62 U.S. 462, 470 (1858).

4. 5 U.S.C. 3333, 7311

5. 5 U.S.C. 3331, 7311

6. 5 U.S.C. 3333, 7311

7. 5 U.S.C. 7321-7327

8. 18 U.S.C. 201-219

9. 5 U.S.C. 5101-5115, 5 U.S.C. 5331, 5 U.S.C. 6301-6324, 5 U.S.C. 8701-8716, 5 U.S.C. 8901-8913, 5 U.S.C. 4301-4308, 28 U.S.C. 2674, see e.g., 26 Op.Atty.Gen. 363 (1907), 32 Comp. Gen. 18.

10. 5 U.S.C. 3309-3319

11. 5 U.S.C. 7151. The policy of nondiscrimination applies to government contractors also.

12. 5 U.S.C. 3303

13. Executive Order 10988, 3 CFR (1959-1963 Comp.)

14. 5 U.S.C. 8331-8348

15. 5 U.S.C. 5336

16. 5 U.S.C. (1958 ed.) 43 note; 65 Stat. 757, §1310 (1951)

17. 5 U.S.C. 5335

18. 5 U.S.C. 5301-5302

19. 5 U.S.C. 4501-4506

20. 5 U.S.C. (1958 ed.) 43 note; 65 Stat. 757, §1310 (1951)

21. 5 U.S.C. 5341-5344

22. 5 U.S.C. 5541-5544

23. 5 U.S.C. 6303

24. 5 U.S.C. 6307

25. 5 U.S.C. 6323

26. 5 U.S.C. 6322, 5515, 5537

27. FPM Supp. 990-2, p. 630-51

28. 5 U.S.C. 8101-8150

29. 5 U.S.C. 8301-8348

30. 5 U.S.C. 8701-8716

31. 5 U.S.C. 8901-8913

32. 5 U.S.C. 5701-5742; 80 Stat. 323

33. 5 U.S.C. 4101-4118

33(a). Executive Order 10096, 15 Fed. Reg. 389 (1950); Presidential Memorandum and Statement of Government Patent Policy, issued October 10, 1963, 28 Fed. Reg. 10943 (1963).

34. 5 U.S.C. 3331, 3333

35. Executive Order 11222; 3 CFR (1965)

36. H. Con. Res. 175, 85th Cong. 72 Stat. Pt. 2-B-12

37. 18 U.S.C. 201

38. 18 U.S.C. 203

39. 18 U.S.C. 205, 207, 208

40. 5 U.S.C. 7321-7327

41. 18 U.S.C. 2071

42. 5 U.S.C. 7352

43. 18 U.S.C. 219

44. 5 U.S.C. 7311

45. 5 U.S.C. 3310

VOL 8 1968

SUPPLEMENT
to the
OPINION OF THE GENERAL COUNSEL
U. S. CIVIL SERVICE COMMISSION
on the
LEGALITY OF SELECTED CONTRACTS
at the
GODDARD SPACE FLIGHT CENTER

The Civil Service Commission General Counsel issued an opinion in October 1967, regarding the legality of selected contracts of the NASA Goddard Space Flight Center. The opinion held that the contracts under review were proscribed by the Federal personnel laws. In addition, the opinion identified six elements designed to assist agencies in determining the legality of support service contracts.

Since the opinion was issued, these elements and the scope of the opinion have been subject to varying interpretations. The purpose of this Supplement is to clarify the meaning of these elements and the scope of the opinion in order to ensure that support service contracts are not drafted or performed in a manner which will evade the requirements of the personnel laws.

It should be understood that support service contracts are not per se proscribed by the Federal personnel laws. In addition, no single provision of a contract, such as the task assignment requirement, a technical direction clause, or a "key personnel" provision, should be used as the sole basis for a determination that a support service contract is or is not proscribed by the Federal personnel laws. Evaluation of the legality of a support service contract must be based on a realistic view of the provisions of the entire contract, and the manner in which it is administered and performed.

The touchstone of legality under the personnel laws is whether the contract creates what is tantamount to an employer-employee relationship between the Government and the employee of the contractor.

The basic criteria by which this relationship is judged are those set forth in 5 U.S.C. 2105(a), namely whether an employee is:

(1) appointed in the civil service by a Federal officer or employee;

(2) engaged in the performance of a Federal function under authority of law or an Executive act; and

(3) subject to the supervision of a Federal officer or employee while engaged in the performance of the duties of his position.

The six elements recited at the conclusion of the Goddard opinion relate principally to the third statutory criterion concerning supervision of a contractor employee by a Federal officer or employee. If the contract terms permit such supervision, or if in the actual performance of the contract such supervision is conducted, the test is met.

The Commission's experience reflects that proscribed supervision is frequently evidenced by the six elements stated in the Goddard opinion. Where the work to be performed under contract is to be on-site, with Government-furnished equipment, involving services applied directly to an integral effort of the agency, of a long duration and where comparable services meeting comparable needs are performed in that or other agencies by civil service personnel; responsible agency officials should recognize the existence of a situation where there is potential for the kind of supervision which evidences an employer-employee relationship.

The absence of any one or a number of these elements would not mean that supervision does not exist but only that there is less likelihood of its existence. Moreover, any single element may not be significant unless its presence is felt to a substantial degree. For example, sporadic, unauthorized supervision over an occasional one of a much greater number of contractor employees might reasonably be ignored; whereas, relatively continuous supervision of a substantial number of contractor employees by Government employees would have to be taken into account.

The same reasonable approach should be taken with respect to each element described in the Goddard opinion. The reasons supporting the first four elements simply restate common experience. Performance of the contract work by contractor employees on Government premises ordinarily facilitates supervision by Government employees. The simple question to be determined is whether the proscribed supervision that can be expected from this circumstance has occurred. Use by contractor employees of Government-furnished equipment creates the same facility for supervision, and warrants similar close inquiry. Since Government agencies are responsible for accomplishing their missions, application of contract services to agency efforts integral to accomplishment of the basic mission is likely to be closely supervised. And where that need is felt, it can be expected that most agencies in comparable circumstances will be filling the need with properly appointed civil service personnel.

The criterion stated in the fifth element is the continuing character of the Government need being met by the contract service. The suggestion that a need for service which lasts beyond a year must be filled by use of civil service personnel does not mean that contracts for briefer periods are invariably permissible. A contract for service to fill a temporary need of 30-60 days duration, but which involves continuous supervision of contractor employees by Government employees, would be proscribed. Finally, the sixth element, which involves a requirement for close supervision of contractor employees by Government employees for the protection of Government interests and functions is a companion piece to Bureau of the Budget Circular A-76 which requires agencies to perform for themselves those basic functions of management which they must perform in order to retain essential control over the direction of their programs.

The agencies involved in contracting for support services have the initial and primary responsibility to review and identify those contracts and contract operations which create the proscribed employer-employee relationship in violation of the personnel laws, and to take appropriate action where necessary. The Civil Service Commission has the continuing responsibility to assure compliance with the personnel laws.

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES
Affiliated with AFL-CIO
1325 Massachusetts Avenue, N.W., Washington, D. C. 20005

MEMORANDUM: 8/OMB/A-76 DATE: 11/14/78

TO: NATIONAL EXECUTIVE COUNCIL, COUNCIL PRESIDENTS, LOCAL PRESIDENTS, DEPARTMENT HEADS, NATIONAL REPRESENTATIVES

FROM: Kenneth T. Blaylock
National President

SUBJECT: AFGE's Comments on OMB's proposed Revision of Circular A-76 Governing Contracting Out

Attached please find copies of AFGE's comments on OMB's proposed changes to Circular A-76. Highlights of OMB proposals include the following:

1. Reaffirmation of government policy favoring reliance upon service contractors.

2. Recognition (for the first time) that "government functions" must be performed by government personnel, regardless of cost.

3. Recognition of taxpayers' right to true economy in contracting out determinations.

4. Reaffirmation of prohibition against contracting out to avoid personnel ceilings.

5. Publication of a (future) supplemental handbook to govern the conduct of cost comparisons.

6. Establishment of the principal that both government and contractor cost figures should be based upon the same scope of work and same level of performance.

7. Use of "full costing" principles for in-house cost estimates, including "government overhead".

8. Retirement cost factor of 20.4 percent.

9. Ten percent personnel cost differential in favor of continued existing in-house performance.

10. Ten percent personnel cost differential plus 25 percent equipment and facility differential in favor of contracting out new starts.

11. Establishment of agency appeal procedure affording employees and their union representatives' standing to contest A-76 determinations. This procedure does not provide for judicial review.

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

COMMENTS AND RECOMMENDATIONS ON PROPOSED

REVISIONS OF OMB CIRCULAR NO. A-76

(August 21, 1978)

AFGE appreciates the opportunity to present its views on the August 21, 1978 proposed draft of OMB Circular A-76 for consideration. AFGE's comments with regard to the various sections are as follows:

Paragraph 2 as proposed provides:

> "Background. In a democratic free enterprise economic system, the government should not compete with its citizens."

AFGE regrets that OMB would even consider the inclusion of this sort of unwarranted introductory remark in its discussion of the background to Circular A-76. This Union and its members have always applauded this Nation's free enterprise system based upon individual freedom and initiative. AFGE knows of no situation in which the employees of the federal government, hired to provide for the needs of the nation's citizenry, are, in fact, in competition with the citizenry.

Government agencies do not, for example, manufacture products for sale in the market place in competition with private business.

In the Preamble to the Constitution of the United States of America, the founding fathers explain that the people of this country came together and formed a government in order to establish justice, secure domestic tranquility, provide for the common defense, promote the general welfare, and secure the blessings of liberty. The government of this nation is not in profit-making commercial business. Rather, our government is a reflection of our founding fathers' adoption of a compact theory of government pursuant to which the citizenry established a republic for the explicit purpose of performing those tasks which they found were required for the common good and unavailable in the market place.

While it is true that the government, in order to accomplish its recognized mission to provide for the national defense, etc., requires the provision of janitorial, audio visual, food services etc. for its own use, the government's provision of these services in the national interest can in no way be considered competition with profit-minded private industry. Unless American History is to be rewritten to assert that our government

was originally founded to duplicate services to the buying public which were already available in the commercial market place. It is sheer nonsense to begin a discussion of the background to Circular A-76 with a statement which assumes that government and private business are in competition for the money of the consumer.

AFGE is tired of the simplistic approach to government which makes non-managerial federal employees the whipping boy for the cost of providing government services during a period of high inflation and seeks to avoid public accountability by placing the delivery of goods and services needed by the government itself in the hands of profit-minded contractors.1/

AFGE submits that the first sentence of section 2 "Background" should be striken for reasons discussed above and, also, because it is inconsistent with the discussion of "government functions" found at section 4(f) of the Circular.

1/ See Attachment A, Internal AFLC memo concerning contracting out of Air Force Computer Programming(Project Max). "We have contract money, but we do not have money to pay for more programmers in house. Let's minimize the impact on our system and maximize the impact on SDC [the contractor]. Then if we have to slip because the contractor is not ready, Air Force Logistics Command's hands are clean." (Emphasis supplied)

Paragraph 3(a) as proposed provides:

> "The Government's business is not to be in business."

This sentence, again, misportrays the functions of government and private industry as discussed above and should be stricken as it adds nothing of legitimate substance to the Circular's policy statement. A housewife who does her own laundry is not "in business"; an air base in Alaska which does its own laundry is not "in business. We submit that a more relevant statement in this period of GSA/contractor scandal would be that: "The business of private industry should not be government."

Paragraph 3(b).

AFGE applauds the inclusion of section 3(b) which, for the first time acknowledges, by way of a policy statement, that certain functions performed by federal employees are inherently governmental in nature and therefore inappropriate for contracting out. However, AFGE, in agreement with the GAO's September 25, 1978 report to the congress on the "Development of a National Make-or-Buy Strategy--Progress and Problems" (p. 76) feels that the proposed Circular in general, and section 3(b) in particular, lacks guidance concerning whether an activity would or would not be subject to the Circular. AFGE suggests the addition of the following language:

> "A function is inherently governmental and should not be contracted out where the general public relies on the government for its performance (e.g. food inspection); where it is specifically assigned by statute to a Federal agency and funds are appropriated to employ federal personnel; where it involves the use of government authority; where it involves the interpretation of public policy; where the President or the congress need to be able to place accountability in a public official for its performance; or where it is in direct support of any of the above."

AFGE also notes that while Appendix A to Circular A-76 lists functions which OMB suggests should be considered for contracting out, examples of the sort of functions to be retained in-house pursuant to Section 3(b) are not provided. This omission may be interpreted as a lack of OMB commitment to Section 3(b)'s policy statement. Accordingly, we suggest that an Appendix B be added to the Circular identifying noncontractable governmental functions along the lines of AFGE's discussion regarding this section and section 4(f)(1) below.

Given the Circular's recognition of the fact that "Government Functions" must be performed by government employees and the fact that the taxpayer is entitled to economy in government, AFGE would also suggest that the second sentence of Section 3(a), which provides that agencies should look to contractors

"first" to provide commercial or industrial services, should be stricken. The sentence is inconsistent with paragraph 3(b) and 3(c) and we believe, renders that guidance which the GAO asserts is necessary with regard to paragraph 3(b) and 3(c) more difficult.

Paragraph 4(f) as proposed provides:

> "A government function is a function which must be performed in house due to a special relationship in executing governmental responsibilities."

While AFGE supports OMB's recognition of the fact that certain governmental functions are inherently governmental in character and may not be contracted out regardless of cost, because to do so would constitute an improper delegation of authority, responsibility, and accountability for the public welfare to the private sector, AFGE submits that the definitional language of Section 4(f) is much too vague to be of any guidance. This provision does not explain what a governmental function is because it fails to indicate what is meant by a "special relationship in executing governmental responsibilities". While it helps to know that governmental functions fall into several categories, such information is no substitute for a definition of a "governmental function".

Accordingly, we submit that "government function" should

be clearly defined along the lines suggested by AFGE in reference to paragraph 3b above.

Paragraphs 4f(1), (2) and (3)

Sections 4(f)(1) and 4(f)(2) provide examples of different categories of governmental functions. AFGE again submits that these categories fall far short of providing the sort of guidance requested by the GAO's report. Many federal managers will, for lack of guidance, simply compare their list of possible government functions to those specified in paragraph 4(f)(1) and (2) and contract out any function not specifically identified therein. Therefore, along with the new definition of government functions provided above, we suggest that the following examples of governmental functions be added to paragraphs (1) and (2): law enforcement; regulation of all aspects of commerce and industry including food and drug ingestion, etc; direction of national defense and security; management and direction of the armed services; development and use of space, the oceans, navigable rivers and other natural resources; development and use of atomic energy; the conduct of foreign relations; intelligence and counter-intelligence operations; the control and management of the public lands; the collection and disbursement of revenues and taxes; control of the public treasury, accounts, and money supply; and the administration

of public trusts, such as the Social Security system, among others.

Section 4(f)(3), the last enumerated category of government functions, identifies the necessity for maintaining an in house capability in areas of research, development and testing, etc. While AFGE supports the identification of this need for in house capability, we feel that the section identifies only one problem area while leaving far more than half of the problem untreated. While the federal government obviously needs an in house research, development and testing capability, we submit that equally necessary is an in house capability to insure (1) an ability to provide for the public's need and the agency's primary mission needs should a contractor breech his contract or become unable to perform for any reason; and (2) to provide a standard by which the government can measure whether or not the taxpayer is getting his money's worth from the contractor. Accordingly, we submit that section 4(f)(3) be amended to provide that activities must maintain a minimum in house capability sufficient to insure that the activity is able to convert to government services should it be in the interest of agency management, the public interest, or the taxpayer to do so.

A third problem with conversions to contractor services is

the fact that once an agency contracts out for certain technical services, such as computer programming, the activity soon becomes the captive of the contractor in that agencies come to rely on such contractors to forecast and evaluate the agencies' on-going needs for services in the contracted areas. Accordingly, 4(f)(3) should be further modified to provide that activities engaged in contracting out shall retain a minimum in house capability necessary to insure an independant agency evaluation of the contractor's performance and activity's needs.

Paragraph 5(d)(3).

Section 5(d)(3) amends section 4(a) of the previous version of Circular A-76 which provided that the circular would not be "used for the purpose of avoiding established salary or personnel limitations."

The proposed language would provide:

> "This circular will not be used to justify a conversion to contract solely to meet personnel ceilings or to avoid salary limitations."

AFGE takes the strongest possible exceptions to this change. If the position of OMB continues to be that contracting out will not be used as a vehicle to avoid personnel ceilings, absolutely no legitimate purpose is served by the addition of the modifier "solely". Indeed, the addition of this word will lead activities

to believe that they may continue to contract out to avoid ceilings as long as any otherwise inadequate additional rationale for contracting out is also identified

As the GAO has repeatedly pointed out, one of the main problems with cost analyses prepared pursuant to Circular A-76 has been activity determinations to contract out to avoid ceilings regardless of cost to the taxpayer. The addition of the word "solely" is clearly inconsistent with OMB's stated objective of giving proper attention to relative costs. As AFGE has repeatedly stated (and the GAO has repeatedly found) personnel ceilings are not a meaningful method of personnel management. They are almost never related to actual workload or manpower requirements. Nor are they in any way related to economy or efficiency. If contracting out decisions are to be made with due regard to the taxpayers interests, it is time to recognize that personnel ceilings may play no legitimate role whatsoever in contracting out decision; and section 5(b)(3) should simply say so.

Paragraph 5(d)(6) as proposed provides:

> "This circular does not apply to contracts awarded under duly authorized set aside programs, including small business, minority business, Indian preference, federal prison industries, and other contract preference programs . . . ".

AFGE acknowledges that statutorily required contract preference plans are beyond the scope of this circular. AFGE believes that the Circular's exclusions should in like manner be broadened to include the significant congressional policy values inherent in the Federal Personnel System and in special employment programs for minorities, disadvantaged veterans, and handicapped employees, etc. While the Circular purports to recognize the interests of these groups by providing that they shall be afforded the right of first refusal by any successor contractor, AFGE again points out that if the government can terminate the handicapped, the retarded and minorities, as it has done and is doing pursuant to Circular A-76, solely on the basis of cost, contractors must be expected to follow the government's example and claim the same privilege.

88-005 O—82——16

Paragraph 7 as proposed provides:

> "Government Operation of Commercial or Industrial activity. Government operation of commercial or industrial activity may be authorized under one of the following conditions."

Since, as stated above OMB's own summary of the proposed revisions of Circular A-76 provides that contracting out decisions are to be based upon appropriate consideration of whether a government function is involved and relative cost, this section should be balanced to indicate that in house performance will be continued under circumstances described in subsections A, B and C of section 4(f), and not merely that continued in house performance is permissive.

AFGE also believes that the second sentence of this section, which provides that "If the function has been performed by contract elsewhere or at another time, the justification must specify why circumstances are substantially different", should be balanced by a requirement that any function previously rejected for contracting out pursuant to subsection A, B or C shall be accompanied by an explanation of the circumstances which have changed in favor of any subsequent contracting out decision. Otherwise, the bias becomes so palpable that OMB's credibility is damaged.

Furthermore, for reasons discussed above, this section should also provide a request that any decision to contract out must be accompanied by certification that the action is not proposed in order to avoid personnel ceilings.

Paragraph 7a(4)(a) as proposed provides:

> "The fact that a program is classified, or part of an agency's basic mission, or that there is a possibility of strike of contract employees is not an adequate justification for in house performance."

AFGE believes that this provision's reference to an agency's "basic mission" will cause confusion, as mission is likely to be interpreted to overlap "inherent government function". An agency's basic mission is obviously another way of describing an agency's "inherent government function". "Basic mission" also means "basic purpose" and, as such, should not be contracted out. Thus, reference to basic mission should be deleted.

While it is relatively a simple matter to administratively direct that the fact that a program is classified or the fact that contract employees may strike etc. shall not constitute adequate justification for in house performance, AFGE's experience has demonstrated that application of such a directive merely results in unacknowledged contract related costs detrimental to the tax payers' interest. (See Attachment B)

Accordingly, AFGE submits that this section should be balanced to protect the tax payers' interest by requiring an estimate and explanation of contract cost for such contingencies as contract breech, employee strikes and contractor employee security clearances, etc.

Paragraph 7b(2)(c).

This section should, as discussed above, be changed to affirmatively provide that in house services will be relied upon when in house costs are less expensive than contractor costs.

Paragraph 8: Cost Comparisons.

AFGE requests the opportunity to present its views upon the early drafts of any proposed cost comparison handbook.

AFGE supports section 8(a) insofar as it provides that both government and contractors costs must be based upon the same scope work and level of performance. AFGE has never believed that a contractor, paying wages required by law, could perform the same work at the same level of performance as federal employees at a lower cost, still making a profit.2/

To the extent that contractors even come close to in house costs, it is generally because poor federal management techniques such as unnecessary multiple levels of supervision, have been allowed to lower in house efficiency. Accordingly, AFGE suggests

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2/ See page 45 of GAO Report on Circular A-76 which notes that it is not unusual for agency cost analysis to be based upon in house manpower authorizations rather than actual in house force relied upon by the activity.

that section 8(a) should be improved by the addition of a provision requiring that management undertake appropriate management studies to ensure that services being considered for contracting out have been structured for maximum in house efficiency prior to the conduct of a cost analysis. Unless such a requirement is added to section 8(a), contracting out done in the name of economy will merely result in the transfer of inefficient, overly expensive services being transfer from the public to the private sector at a continuing disservice to the taxpayer.

Paragraph 8 (a)(4).

In those areas of service contracts where "buying-in" has been shown to be a problem, the government should restrict the initial contracts to one year and open them up again to competitive bidding for the next year. During the term the government should hold the contractor strictly to the terms of the contract. Increasing the period of the initial contract to two years would merely result in a two-year "buy-in" period for a service contractor looking toward a long-term contractual relationship. It is no answer to the problem.

Multi-year service contracts, on the other hand, have the distinct disadvantage to the government of the loss of ability either to change contractors or to change readily the terms of a contract where (a) the often new and unknown contractor does not perform satisfactorily or (b) the initial statement of work and performance requirements in the contract turn cut to be inadequate or erroneous.

In other words, AFGE believes that efficient performance of government work and the integrity of the procurement process must be considered to be as important as the money paid out. Indeed, better performance and greater integrity should also result in the saving of the tax payers' money.

Paragraph 8(a)(5) as proposed provides:

> "Cost comparisons are to be aimed at full cost, to the maximum extent possible in all cases."

AFGE, in agreement with the GAO Report on Circular A-76 (page 78), disagrees with the use of fuller costing in all cases as potentially inconsistent with the policy objective of economy in government and as an unnecessary potential bias toward contracting out with private industry.

Paragraph 8(a)(6).

Paragraph 8(a)(6) provides that agencies may convert to contractor services without the benefit of a cost analysis if the estimated in house cost is less than $100,000 per year. AFGE disapproves of this new figure which is double the previous dollar amount, because it allows contractors to take over work without regard to cost effectiveness and is therefore contrary to OMB's asserted policy of protecting the taxpayers' interest. No service contract should be awarded merely because the cost is less than $100,000. If OMB's asserted pro-taxpayer policy is to be credible, conversion to contractor service should never be approved unless less expensive than in house performance.

Furthermore, the proposal does not make provision for assuring that in house operations costing less than $100,000 are properly reviewed and structured, like any others, to correct any poor management practices, referenced above. Failure to add such a requirement will merely transfer inefficient and over-costly performance from the public sector to a contractor at excessive cost to taxpayers. Once transferred to a contractor, the opportunity to improve its management is forever lost.

Finally, the proposed provision provides: "reasonable effort should first be made to obtain satisfactory pricing from existing

commercial sources and to develop other competitive commercial sources." This provision lacks enforcement mechanisms. In its present form, section 8(a) constitutes an open season on taxpayers for all services under $100,000.

Paragraph 8(a)(7)(c)(1) as proposed provides that for purposes of calculating costs of government operations:

> "Each agency should assure that government operations are organized and staffed for the most efficient performance."

AFGE supports this proposed change. However, merely encouraging agencies to review their organization and staffing for efficiency purposes as part of a cost analysis effort will, we believe, prove insufficient because (1) agencies burdened with cost analysis are unlikely to voluntarily burden themselves further by conducting internal reorganizations and (2) what is really needed is not further agency reorganization but rather an agency initiative geared at identifying unnecessary supervisory duplication and waste and improper in house costings practices. AFGE suggests that extensive provision be made in the forthcoming supplemental handbook to assure that the exhortations of this section are met. AFGE suggests that this part of the handbook should be drafted cooperatively by OMB and affected employee representatives.

Paragraph 8(a)(7)(c)2.

This section provides for a 20.4% retirement factor for calculating in house salary costs. AFGE continues in its opposition to this proposal and will address it in further detail when provided the opportunity to review the cost comparison handbook. Accordingly, at this point AFGE would simply note that OMB's proposed cost comparison handling of retirement has the obvious effect of rewarding private employers with the least progressive and/or least responsible retirement systems.

A contractor with no private retirement system for his employees will obviously be in a superior bidding situation to a contractor with an established retirement system which has incurred past service liabilities. Likewise, a disreputable contractor who establishes a retirement system only to change his work force repeatedly or to go into repeated bankruptcy to get out from under his system will fare better than a contractor who chooses to assume his social responsibilities. This will throw a heavy financial burden on the federal government in "insuring" these systems.

As regressive and unwise as the effects of the 20.4% proposal would be on contractor employees, their effect upon federal employees is even more indefensible. Obviously this proposed retirement percentage will, if adopted, result in federal employees, whose retirement benefits are set pursuant to established law and congressional policy, losing their jobs simply because of the

retirement system which was established for their benefit. The example to the private sector will be obvious. If the federal government can, as an employer acting pursuant to an Executive Circular, terminate its own employees because of the cost of their retirement program, private sector employers would assume the same right. AFGE seriously questions the legality of administratively evading congress' retirement policies for federal employees.

Paragraphs 8(a)(7)(d) and (3).

Given the Circular's assertion that contracting out decisions are to give appropriate consideration of the taxpayers' interests, AFGE submits that the 25% differential found in section (e) but omitted in section (d) should be dropped. Its inclusion clearly indicates a pro-contracting out bias, inconsistent with the Circular's new asserted policy.

Paragraph 9(a)(4)

This section should be amended to read:

> "Each agency will recognize that work for the federal government may be performed by the appropriate use of military personnel, career civilian employees and contract services

> and that past experience demonstrates that all three methods, properly utilized and managed, have been responsive and dependable in accomplishing appropriate, sensitive and important work."

We believe these changes are necessary because the use of military personnel is not appropriate for each agency of the federal government, and reference to "in-service" civilian employees creates a new and unnecessary term for federal employees-the balanced use of which would require the use of the term "out-service" contract employees. Furthermore, experience has shown, as reflected in numerous agency reports, that reliance upon contractors has often proven less than satisfactory.

Paragraph 9(a)(5)(b).

This section provides that federal employees displaced as a result of the conversion to contract performance shall be provided a right of first refusal by the employing contractor. Since 8(a) "Cost Comparison, Common Ground Rules" provides that contractor bids are to be for the same scope of work and performed at the same level of performance as was performed in house, AFGE would add a clause to this provision indicating that such employees shall be presumed qualified for contractor employment to perform work previously performed as federal employees.

Paragraph 9(c)(2).

This section provides that agencies will review existing contracts to see if they can be performed cheaper if reconverted to in house services. The provision goes on to provide "When this is determined to be likely, the cost comparison will be conducted."

AFGE suggests that this provision is likely to be ignored by agencies. Unless an agency is mandated to review its contracts for possible conversion to in house performance on a regular basis, agencies will simply assume, in the absence of a cost comparison requirement similar to that required for continued in house performance, that contractor costs are at least less than 10% of the continued in house cost. The Circular's credibility requires that conversions and reconversions receive similar treatment.

Paragraph 19(b)(1).

The proposed handling of new starts is biased toward contracting out and disregards above referenced OMB policy considerations concerning the nature of government functions and taxpayer protection. This section provides a blanket prohibition against the initiation of in house services unless they can first be

justified, but fails to provide a similar prohibition against contracting out until such time as resort to contractor services is determined to be cost effective and in accordance with Circular policy. Accordingly, AFGE suggests that this section be modified by the addition of a prohibition against resort to contractor services pending a determination of whether the service is a government function or the completion of a comparative cost analysis. The taxpayer and the government are ill served by a Circular which, by placing one-sided obstacles in the path of in house new starts, promotes the use of contractor services by default.

AFGE also objects to the use of $500,000 in the definition of new starts. There is no basis for this 500% inflation in the regulation.

Paragraph 10: Appeals.

Section 10(a)(2), which provides that the agency appeals procedure established pursuant to section 10(a)(1) shall provide for a determination by an agency official at the same or higher level of the agency considered with contracting out action, is clearly inconsistent with section 10(a)(1) which provides that the appeals procedure must involve an <u>independent</u> objective review of all contract decisions. In order to be an independent review

authority, as required by section 10(a)(1), the reviewing authority will have to be outside of the normal chain of command or decision making and therefore could not simply involve reference to an official at the same or higher level of the decision making process. AFGE supports section 10(a)(1)'s provisions for an independent review body, and suggest that this could be achieved by establishing a board of review with authority to issue final decisions without regard to inappropriate management, contractor or union input. To accomplish this goal, a board should be established outside the agency's chain of decision making, be able to hold hearings, call witnesses, and order final corrective action including the stay and rejection of contracts.

Paragraph 10(c).

This section should be amended to provide that federal employees "or their exclusive representative" shall have access to the appeals procedure of section 10.

The reference to agency decisions as final should be replaced with language stating that the decision of the independent review body shall constitute the agency's final decision.

SUBJECT: Memorandum for the Record, 19 May 1977 (3 a.m.)

1. Personnel in attendance. Personnel in attendance included the (G037G) personnel from C, ACV-1 personnel Lt Col Precious, Maj Bradshaw, Frank Dion and Gary Girelach, and Lt Col Dwyer.

2. Subject/Purpose. The purpose of this meeting was to review the viewgraphs developed by the G037G personnel for the pitch to be given to AC/MA. The viewgraphs indicated that, because the G037G system would require several new functions under UCA-1, it would retain approximately its same size even though some of its edits would be accomplished by the source data collection (SDC) system. Lt Col Dwyer stated that "systems should decrease in size by approximately 50 percent because we are buying a front end computer the size of the 70-80 and ten times faster. Maybe we are not using the SDC mini computer right?"

3. We then spent some time exploring the size of the G037G employee master and decided that it was small enough (2 million characters) to be maintained on disc in the SDC system. Lt Col Dwyer instructed us to identify the different types of functions that were more properly suited for either the SDC equipment or the host system equipment. Two different types of categorization were discussed items or functions that were better suited to batch (overnight) processing would probably stay on the host system equipment (CYBER). Those functions that required real-time accessing and were better described as data gathering would probably be accomplished in the SDC system. Another way of breaking out functions between SDC and the host systems would be by the degree of variability that we could expect in the future; things that we know will probably change should be kept in the G037G system, while things that are known to a degree of certainty should be put into the SDC system.

4. The rationale for the preceeding attempts to shift functions from the host system to the SDC system was given by Lt Col Dwyer; "We have contract money, but we do not have money to pay for more programmers in-house. Lets minimize the impacts on our systems and maximize the impact on SDC. Then if we have to slip because the contractor is not ready, AFLC 's hands are clean."

ATTACHMENT A

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS FOREIGN TECHNOLOGY DIVISION (AFSC)
WRIGHT-PATTERSON AIR FORCE BASE, OHIO 45433

11 JAN 77

TO: THE COMMANDER

SUBJECT: Janitorial Escort

TO: All FTD Personnel

1. The additional expenditure of mission resources to escort contract janitors remains of serious concern to me, especially as it causes inconvenience to my own work force. I have laid special emphasis on an emergency manpower request to obtain an in-house janitorial work force which can be vault cleared.

2. In the interim, however, a new approach to escorting is necessary to curtail the excessive overtime costs experienced thus far this fiscal year. The attached procedures will therefore become effective 31 Jan 77.

3. I request your cooperation to insure the new procedures are implemented without undue complication. Again, I consider this an interim measure only, pending establishment of our own janitorial capability.

John B. Wanless, Jr., Colonel, USAF
Commander

1 Atch
Janitorial Escort Guidelines

ATTACHMENT B

JANITORIAL ESCORT GUIDELINES

1. All civilian personnel up through GS-9 and enlisted personnel up through E-6 with vault access will be assigned janitorial escort duty.

2. The assignment will be for a duration of one day on a rotational basis among all qualified personnel in the above-mentioned grades. A 10% night differential will be paid in addition to the employee's basic rate during the one day temporary shift assignment. It is anticipated that individuals will be given this one day temporary shift assignment approximately once every 90 days. Exceptions will be approved by the Chief of Staff or Commander only.

3. Personnel will be assigned work schedules from an alphabetical name listing to be developed, maintained, and circulated by the Directorate of Operations. This listing will project shift assignments as far into the future as practicable. When presented to affected employees, this listing will constitute notification of a temporary change in work shift for the date indicated in accordance with AFR 40-610.

4. Personnel with work shift assignments may personally arrange for substitutes from the list of qualified personnel as defined above. This will be done in writing to DO, and will be forwarded along with the written concurrence of the person agreeing to be a substitute and a written concurrence of both supervisors. DO must be notified of substitute arrangements at least seven days in advance of the temporary shift assignment.

5. Hours of work during the temporary tour of duty will be from 1400 to 2300 hours. A dinner break will be observed from 1600 to 1700 hours. Personnel will report to their regular duty assignments from 1400 to 1600 hours. Janitorial escort duty will be performed from 1700 to 2300 hours.

Attachment 1

AFGE's VIEWS ON THE 'PROPOSED CHANGES IN POLICY OF GOVERNMENT RELIANCE ON PRIVATE ENTERPRISE" TRANSMITTED NOVEMBER 22, 1977

We appreciate this opportunity to have our views seriously considered in the review and revision of OMB Circular A-76.

Although the study to date indicates a studious effort to rationalize this most difficult area of policy and contains a number of laudable improvements, we are greatly distressed by the:

1. uncritical adherence to the ill defined precept of reliance upon the "private sector" for both goods and services;

2. use of general economic assumptions and dynamic normal costs projections for the civil service retirement system;

3. subjugation of minority, handicapped and veteran rights, and pay comparability principles enacted in the Federal personnel laws to sheer cost considerations;

4. failure to require that in-house operations be first restructured to meet cost objectives and that work statements and contract cost comparisons be based thereon;

5. use of disparate cost differentials and thresholds for in-house and contractor operations;

6. failure to provide an independent appeal mechanism to determine A-76 violations of the Federal personnel laws; and,

7. failure to establish a meaningful budget and accounting procedure for Government contractor operations and a central repository of data available to all interested parties.

The "Precept" Formulation

We reiterate our earlier submission with particular emphasis upon a more discrete formulation of the "precept" of Government reliance upon "the private sector" for "goods and services". There is no historical, legal, or logical support for the precept that Government inherently relies upon "the private sector" for services. Indeed, the opposite is true. Government per se is inherently a service function required under our constitutional system to be provided by Government employees for the essential reasons discussed in our prior submission. This precept simply should not be applied in such an overstated context as it sweeps too broadly.

Further, we emphasize that the so-called "private sector" insofar as the bulk of Government procurement is concerned is a highly specialized community of contracting organizations, including corporate structures having both conglomerate and multi-national aspects, as well as relatively small organizations created solely for the purpose of acquiring Government business. Such a diversity of interests simply should not be uncritically categorized as the "private sector" upon which to predicate Government reliance. Elements of the "private sector" are involved in the procurement process in varying degrees and indeed some segments are not involved at all and eschew becoming involved. The definition of "private sector" should be refined to more validly comprehend the characteristics of the interests concerned. Unless this is done, policy revisions in A-76 are likely to be skewed and inapposite to desired objectives.

A current example of the all inclusive nature of the precept is the award to Mitsubiski Motors of Japan of a 5.1 million dollar contract to supply the machine tools on the turret for the XM-I army tank. Chrysler, which owns 15% of Mitsubiski Motors, was awarded the turret contract and had recommended that the critically important machine tool sub-contract be awarded Mitsubiski Motors. (See Evans and Novak, Washington Post, January 11, 1978). Is this the "private sector" that A-76 commits our Government to rely on for essential goods and services? Is the multi-national foreign based producer to be preferred over national producers? Are foreign workers to be employed and paid with taxes from American workers, who are then put out of work by an unrefined policy precept mandating reliance upon such foreign sources as part of the "private sector"?

AFGE has, under this precept painfully experienced the RIF of hundreds of its members on Guam whose ship repair work for the U.S. Navy was contracted out to Japanese and Philippine workers. Is this the policy precept that is to be promulgated or perpetuated as a result of this study?

We ask that this bullet be bit. We do not intend to let go unchallenged a precept that sweeps into the equation foreign labor and foreign wage rates and working conditions to displace American workers both within and without the Federal Government whose taxes are used to pay the foreign workers.

We believe one major reason this now occurs is the use of the shibboleth "private sector" in the formulation of the precept and policy in A-76. Accordingly, if the objective is not to use the taxes of the American worker to take away his means of earning a living, the precept elements must be analyzed and stated in precise and definitive terms. Our earlier submission contains considerable analysis and discussion which should be helpful in arriving at a more appropriate definition of such interests.

Proposed Action: As an absolute minimum it should be stated without any equivocation whatsoever that no contract shall be let which effectively displaces American workers with foreign workers to provide goods or services to the Government of the United States. In short, as a minimum the use of foreign labor or foreign capital in preference to American labor and American capital should be excluded from the concept of the "private sector". Moreover, any precept as to reliance upon the "private sector" should be limited to products and exclude "services".

Use of Dynamic Normal Costs for Civil Service Retirement Costs

With respect to the "dynamic normal cost" methodology for use of cost comparisons, we vigorously challenge that method's validity as a "current cost" determinate. We note that applying the same method to corporate retirement systems would render many of the prime contractors financially unreliable on a current basis and therefore disqualified to be awarded Government contracts. See Fortune Magazine, December 1977, "Those Pension Plans are even Weaker than you Think", pg. 104. Congress has mandated in the

Employees Retirement Income Security Act of 1974 (ERISA) a public policy imposing strict standards of funding, financial disclosure, fiduciary responsibility for plan administrators, and insurance for private sector retirement plans. If dynamic actuarial methods are to be applied to Government costs, the revisions of A-76 should acknowledge this change in law and expression of congressional policy and utilize similar dynamic actuarial methods for computing the costs of the requirements which ERISA impose upon Government contractors. Hence, where contractors have a defined benefit plan (which is the most prevelant type of private sector plan) dynamic normal costs should also be applied and the costs attributable to the contract workers calculated as part of the cost of contracting out. If the contractor is to meet his ERISA obligations, his prorated costs must be included in the price charged the Government, plus a profit. Under the congressional mandates enacted in ERISA, the Executive Branch would be remiss indeed if it adopted a policy which piled up unfunded liabilities in private retirement plans due to contracting policies based on the lowest bid, ignoring ERISA funding requirements.

As a further independent ground of objection, related to this subject, private sector employer contributions to retirement accounts are tax exempt and no consideration is accorded this factor in computing tax loss implications of contracting out. Further, social security benefits are income tax free, whereas Federal employee retirement benefits are not, which again is ignored as a tax-loss-cost which the Government experiences as a result of the contracting out decision.

It is also noteworthy that the actuarial assumptions as to wage increases, interest rates, and inflation, would affect costs on both sides of the cost equation insofar as future liabilities are concerned, however, they are applied to only the in-house cost via the civil service retirement formula. This disparate treatment is completely unjustifiable.

What is even more significant is that the wage and interest assumptions being based on the general economy are more apposite to the "contractor" than they are to civil service retirement. Indeed, it is our position that the assumptions are improper for application to the civil service retirement fund.

With respect to the "average real wage increase" of 1.5% proposed for application to Federal employees, the historical data as reflected in the Reports of the Federal Pay Agent and Pay Council, show that there has not been a "real increase" in Federal pay over the past decade, but rather a "<u>real decrease</u>" has occurred. Also, it should be noted that Federal wage rates are controllable by the President and his agents, whereas private sector contractor wage rates are not, which makes general economy assumptions less valid for application to this factor.

For example, the index of PATC wage increases maintained by the Bureau of Labor Statistics show an increase in that index for private sector wage rates of 45.6 percent from June 1971, to March of 1976, whereas the index series of GS pay increases rose only 34.3 percent during the same period. In short, Federal GS pay

lagged 11.3 percent behind the comparable private sector wages. (See Report of the Federal Employees Pay Council to Advisory Committee on Federal Pay, August 17, 1977, pp. 21-22). The constant dollar earnings of a GS-5, Step 4 Federal worker, actually declined during the period October 1972 to April 1977 from $6,886 to $5,629 resulting in a decrease in real wages (see ibid. pg. 22).

Consequently, it is a gross distortion to apply to Federal employees a 1.5% real wage increase assumption which is essentially a general economic assumption for the overall private sector wage rate, when as a historical fact Federal employees have experienced a real decrease over the past decade due to Executive control of their pay rates. The proper actuarial assumption with respect to real increases in Federal wage rates should be 0%. This correction alone should result in a 15% reduction in the projected 27.4% total cost or a net cost in the range of 16.5% of payroll using the other two assumptions.

Accordingly, we submit that the proposed use of a general economy wage assumption is improper.

Proposed Action:

1. Discard the use of dynamic normal costs as it injects uncertainty and disparity into the comparative cost analysis, unduly inflates the in-house costs and understates contractors' costs. Continue to apply the present cost factor based on net retirement outlays, offset by contributions as adjusted on a yearly basis.

2. If dynamic normal costs are used, change the economic assumptions upon which dynamic normal costs are calculated to those more valid to public employee-CSC experience, namely: average real wage increase of 0%.

The use of net retirement outlays is simple, accurate, and just as it more realistically reflects actual costs to the Government. Moreover, it more nearly approximates the true dynamic normal costs which would result from the use of appropriate assumptions.

Of further importance is the fact that the CSC retirement system and hence its costs are the subject of immediate congressional concern and study. Proposals to merge it with the social security system or to change its funding or benefits formula strongly suggest that no change should be made at this time in the cost computation for retirement. The need for stability and predictability in this area is repeatedly stressed throughout the draft proposals. This need would be best served over the next few years due to the unusual circumstances noted by adhering to the present cost factor methodology until the future of the civil service retirement system is resolved.

The Subjugation of Minority, Handicapped, and Veteran Rights, and Pay Comparability Principles to the Single Element of Cost

The proposed changes recognize that A-76 now allows contracting out decisions which impact upon significant policy values inherent in the Federal personnel system and in special employment programs for minorities, the disadvantaged, veterans, and the handicapped. It is proposed to continue to subjugate all such values in final analysis to costs to which we must take vigorous exception.

For example, proposal 4C, page 34, recognizes that special preferences for veterans and special employment programs for minorities, women, the disadvantaged and the handicapped, are directly impacted by contracting out decisions. The proposed solution is to stress that Government contractors are subject to the same equal employment opportunity laws as the Government and to suggest that increased enforcement of such requirements among contractors would extend even greater opportunity to these target groups by extending the scope of these laws through the procurement process.

We find this rationale shocking and incomprehensible. Contractor compliance with EEO requirements is universally recognized as disgraceful. Federal enforcement has been lax and inefficient. When compliance is required it often results in tokenism at increased costs to the Government.

AFGE has dozens of documented cases of the adverse impact upon minorities and the handicapped of contracting out practices. In the base support area alone, the impact has fallen most heavily upon minority and disadvantaged, low paid custodial, food service, and guard force employees, including the handicapped and retarded. To allow costs to override the social values and the expressed congressional policies undergirding these programs as part of Federal employment is a horrendous perversion of purpose. <u>If the Government can terminate the handicapped, the retarded, and minorities, as it has done, on the sheer basis of costs, should not the contractor</u>

be allowed the same privilege? Indeed, a profit oriented company has more economic justification for such a course than does the Government.

We note that the Civil Service Commission is presently proposing radical and innovative special employment programs for these same employee categories while OMB is simultaneously here proposing to allow contracting out to continue to decimate the principal Federal employment opportunities which presently exist for these groups. A-76 has permitted a serious interdiction of Executive Branch EEO efforts in the past. Under no circumstances should this counter-poised policy be rationalized or allowed to continue.

Proposed Action: That contracting out be barred which affects career opportunities for minorities, handicapped, women, or veterans, unless it is certified by the CSC, i.e. Merit System Protection Board (or the EEOC) that such action will not adversely affect the Government's EEO program or decrease employment opportunities for the affected groups involved. Under no conditions should the policy of A-76 condone the removal of such employees to accommodate turning their jobs over to contractors (see discussion of "tenure", infra.)

Compliance with the Mandates of Tenure and Pay Comparability in the Civil Service Laws

This significant aspect of A-76 is dismissed in the proposed changes by the curt statement that "Consequently there is no inherent conflict between Circular A-76 and civil service personnel policies which have their basis in law, Federal regulations, executive orders, etc.", pg. 34.

There are two basic and pervasive conflicts between the policies of A-76 and legal principles inherent in the Federal personnel laws, including the pay statutes and collective bargaining rights under E.O. 11491. They are:

1. the civil service precept of tenure; and
2. the principle of pay comparability.

Both of these principles are eroded and evaded by the application of A-76 as presently constituted. Civil service tenure has been determined by the Supreme Court of the United States to encompass a property interest warranting the protection of the due process clause of the Constitution, see Arnett v. Kennedy, 94 S.Ct. 1633. This system of tenure wedded to a mandatory retirement age and a retirement system, was designed to ensure that the civil service could attract and retain qualified employees of every needed skill. Tenure is the backbone of a career system - the sine qua non to maintenance of governmental efficiency, effectiveness, and most importantly that "critical core of competence" needed if the public interest is to be served and protected by public employees hired under the merit system. Equally important is the congressionally mandated principle of "pay comparability" with the "private sector" so that the public service can attract and retain competent personnel.

Contracting out on the basis of comparative costs is diametrically opposed to these essential principles of law. It is axiomatic that policy is subordinate to and must comply with law.

This conflict cannot be dismissed on the mere assertion there is no conflict or inconsistency in the policy orientation of A-76 with these mandates. The thousands of tenured career employees, many with decades of service, who have lost their Government jobs to a contractor employee on the basis of lower wage rates can testify to the sense of foul play and betrayal they experienced as a result of this policy. As long as this policy continues, litigation will ensue. No where do the proposed changes meet this issue head on. No where is there presented a justification or rationale for the debilitating impact of A-76 contracting out decisions upon these legal principles and the employee rights they confer.

How can the Executive set Federal wage rates on the basis of comparability under statutory procedures involving the collective bargaining process and then contract out the jobs of its own employees because their wages are too high? Isn't it both illegal and immoral for the Executive to set Federal pay under law and then, in total disregard of tenure or fairness, adopt a policy which places the employees' work on the job market to be awarded to the lowest bidder? Doesn't such a policy make a mockery of tenure and of pay comparability, both of which constitute property interests of the employees involved?

88-005 O—82——18

We believe the answers are self-evident. The first obligation of the Executive is to uphold and enforce the law.

Proposed Action: Prohibit the letting of contracts under A-76 which result in the displacement of any tenured career employee.

Failure to Require that In-house Operations be first Restructured to Optimum Efficiency before being Costed for Contract Comparison Purposes

We believe it somewhat incongruous that the cost efficiency orientation of A-76 completely ignores the basic management principle that it is ordinarily more cost effective to improve efficiency in an ongoing activity than it is to start a new one. Nor is any consideration given in A-76 to improving the efficiency of the in-house operation to meet cost targets. It seems sensible to us to have an in-house activity continue to operate, if it can be restructured to meet cost targets and at the same time satisfy performance requirements. A-76 simply fails to recognize the positive aspects of such an approach, or the negative aspects that result from changing from in-house to contractor provided services with all the attendant disruption to the work force and related costs in money, morale, and performance.

For example, proposal 1F would extend A-76 policies to the procurement of products or services among agencies as authorized by the Economy Act (31 USC 686). We strongly oppose this extension as contrary to law and to the principle of tenure provided by the personnel laws. The statement on pg. 7 of the draft that: "The use of excess services, however, may tend to perpetuate an excess manpower situation in the providing agency resulting in

in Federal employees being retained primarily to perform reimbursable work for another agency", reflects the egregious disregard in A-76 of the principles of the Federal personnel system and of sound management concepts that foster efficiency in the bureaucracy. Rather than focus A-76 policy on getting rid of the trained, tenured career civil servants and replacing them with contractor employees, would it not be better to suggest the transfer of such employees to the rolls of the requesting agency? Where this is not the most efficient course, due to established plant and facilities, the operating economics envisioned by the Economy Act constitutes the method Congress has authorized for one agency to obtain needed services from another which is in a position to provide them. Here again A-76 policy is elevated over a procedure provided by statute which reflects a congressional judgement as to a method of making government operate more efficiently.

We can respond to the proposal in 4F to give qualified Federal employees who lose their jobs first preference for contractor positions only with cynicism. AFGE has too long and too often experienced the tragedy of its members often of advanced age, low education, and mostly minorities, who have lost their jobs to guard, custodial or maintenance contractors who really have no ready manpower pool to perform the contract which they were awarded. They are heavily solicited to take back their former Federal jobs -

at greatly reduced pay and benefit. To propose that they be given a preference by the contractor is simply adding insult to injury. We reiterate the balance of legal and equitable considerations to which policy must conform, precludes contracting out of Federal jobs, which are currently being performed and which are currently necessary if it results in the loss of a position to a career employee or the loss of a job opportunity. If such is recognized in the revision of A-76, proposal 4F and a number of similar proposals would be unnecessary.

The Use of Disparate Cost Differentials

Concerning cost comparisons in part 3 of the proposals, we object thereto for the reasons stated above, however, we have no objections to development of a handbook and specific guidelines consistent with our policy positions noted. Of particular force we repeat that any cost comparison should be fair and should be predicated upon restructured in-house operations designed to meet the desired cost objectives. In short, if cost targets must be met, the in-house operation ought to be given the cost target and allowed to show how it can meet it in-house while also satisfying desired performance levels.

We have no objection to using firm bid procedures (3C) or the prescription of standard cost factors as proposed in 3E.

We commend and support the in-house-continuation-cost preference in 3E, however, we believe it should be 20% not 10% of estimated personnel costs. We urge its extension also to capital facilities as they are intregal to most Government operations. We note that a 25% differential in favor of contractor performance is applied to capital investment with regard to a "new start" under proposal 3F. It simply is not economically sound or justified to skew the cost factors for an existing activity in favor of contracting out by eliminating the capital investment represented by Government facilities and materials necessary to the in-house operation.

Proposed Action: Increase the in-house differential in 3E to 20% of estimated personnel costs and to estimated depriciation on capital facilities, materials and supplies.

Our responses to proposals 3G, H, I, J, and K are covered above in our discussion of the use of dynamic normal cost projections.

As to proposal 3L we support making the contractor cost elements more specific, however, we object to the reduction of the maximum value of contract incentives or premium costs on the theory they are seldom earned. The Government is irrevocably committed to pay the total amount that can be earned and its obligation to do so is the proper measure of the contractor costs. Also, the costs of either mothballing, disestablishing, or disposing of Government facilities, including capital losses in market values, should be included in contractor costs. The proposition that training and relocation costs for reassignment of Government personnel are proper only to the extent they will exceed normal

With respect to agency overhead costs and the 3N proposal to use OMB Circular A-94 for present value analysis, we interpose no objections, if in-house activity is permitted the opportunity to restructure or modify itself to meet efficiency goals. We insist however that capital depreciation amortization periods be truly comparable for both Government and commercial interests.

On page 32 of the draft it is noted that DOD agencies are encouraged to contract for services for three years. We take strong objection to this procedure. Military appropriations are constitutionally limited to one year and contracts are normally limited to one year. Cost projections over a three year period create gross distortions in mythical out-year savings which are used to offset the current year costs which almost always disfavor contracting out. We insist that contract costs comparisons be limited to one year and that out-year projections of savings under contract be barred from cost comparisons all together. Given a three year term, the in-house activity could be reduced and redesigned, through attrition, transfers, training, and productivity improvements to meet the same cost objectives. If three year projections are to be used on the assumption the contractor's performance will remain at initial levels, be satisfactory, and result in no cost changes, then similar assumptions should be indulged for the in-house plan to equal such performance on a three year time frame.

Proposed Action: Bar three year contractor cost projections in comparative cost studies or extend the same time frame to in-house cost estimates for restructured in-house activity designed to achieve target efficiency levels.

Failure to Provide an Independent Pre-Award and Appeal Mechanism

We commend proposed action 4B to specifically prohibit contracting that establishes an employer-employee relationship between the Government and the contractor in accordance with FPM letters 300-8 and 300-12. However, this proposal will be ineffective without an enforcement mechanism to ensure compliance. At present, the Civil Service Commission has a very inadequate system of investigating such contracts, after-the-fact, i.e. after the Federal employees are RIFFED and the contract is being performed. We request that there be created a pre-award procedure before the "Merit System Protection Board" soon to be established as part of the President's reorganization of the Civil Service Commission. The Board would examine challenged contract proposals and make a determination as to whether or not the contract violates the Federal personnel laws. Such a procedure would be eminently more fair than, after the fact litigation, when the employee's rights have already been abridged or where a remedy to the affected employee inflicts unnecessary injury to the contractor.

Proposed Action: That a pre-award challenge procedure be adopted whereby contracts which apparently violate FPM Letters 300-8 and 300-12, may be reviewed by the Merit System Protection Board. The Board's determinations would be administratively final and would be reviewable in the U.S. district courts under the Administrative Procedures Act.

The agency level appeal mechanism to be established by proposed action 5D is unacceptable. Our opposition is not based on the proposition that honest persons cannot be found to do an objective job (which is nonsense). We emphasize that we are addressing the structure of a system not the honesty of individuals. Obviously a system which provides for an authority free of the source that made the decision is a better and fairer system than one that has the same authority sit in judgement of its own acts. Our experience teaches us that within agencies there is often considerable disagreement over contracting out decisions. Many managers privately tell us they prefer in-house operations, but are forced to go contract by high level management. We know that in DOD the impetus for contracting out in recent years has come mainly from the Assistant Secretary level. We simply have no confidence in a system which takes the dispute to the authority that created it. We support the concept of an A-76 appeals mechanism. We believe it should be in OMB when solely the procurement aspects are involved and in the Merit System Protection Board when the challenge involves compliance with personnel laws and policies.

Failure to Establish a Meaningful Budget, Accounting and Data Repository for Contracting Activities

We applaud the clarification of the policy relationship between A-76 and personnel ceilings. We propose, however, a clear, unequivocal statement to the effect that personnel ceilings, which the Comptroller General of the United States has characterized as a "barrier to good management", be eliminated as an OMB imposed control. We recognize that congressionally imposed ceilings are

beyond the authority of the Director of OMB, however, the administrative ceilings are not. Admittedly, the mere presence of such ceilings skew A-76 applications and indeed force contracting out in inappropriate cases. We ask that they be eliminated. If they are retained, however, we recommend that the Circular be modified to make it unequivocally clear that personnel ceilings will be made available and that agencies <u>are obligated</u> to request such relief rather than contract-out on this basis alone.

We have no objection to recognition of the merits of all workers, public and private sector, as proposed in 4D. We support better contract administration, performance monitoring, and enforcement as proposed in 4E. We particularly underscore the need for carefully prepared and comparable work statements, however, here again we stress that such work statements should reflect the restructured in-house activity, to achieve the most efficient operations possible. It is these statements that should then be costed and become the basis for the comparative cost analysis prescribed in the A-76 decisional process.

We support the objectives of the proposal in 5A to establish and maintain in each agency central points of contract and central inventories of all A-76 justifications and contracts which would be readily available to all interested parties. We do not believe however that the mere direction that this be done will achieve it as past experience demonstrates.

We have suggested and we repeat that there should be a two part program. One aspect would be carried out within the normal budget formulation process which separates in each agency's budget its contracting operations. These should be identified as to total costs, services or products obtained, and the quantities thereof, the number of man years of services obtained, the principal skills involved, the costs per man year, etc. In short, a correlation similar to the agency's Salary and Expense Budget.

The other part of this program would establish a central repository of information maintained at OMB, GSA, or a central staff agency. Agency level centers as proposed in 5A would, of course, be needed, however, such centers alone are not enough and simply to prescribe that they be established and that information be made available will not make it happen.

Proposed Action: Than contracting operations of all agencies be budgeted and accounted for in correlation to the regular salary and expense budgets of agencies. That a central repository of all relevant data be established in OMB, and that agency centers be established as a necessary substructure to the above.

The pre-planned periodic review of both in-house and contract operations set forth in proposal 5C is unobjectionable. We appreciate the intent to apply equal treatment to the review process as this has not been the case in the past.

Comments as to Remaining Proposals

Consistent with the above, we have no objections to the systemic improvements proposed to add greater clarity and certainty to procurement operations such as more definitive discriptions of "basic governmental functions" which cannot be contracted out, proposal 1B; or the development of criteria concerning "program disruption", proposal 1C (except to emphasize that an action which would result in dismissal of any tenured employee would, per se constitute such cause); or the development of criteria concerning "military readiness", proposal 1D; or the requirement for advertising, proposal 1E, except to note in the latter instance this constitutes a contract cost increase.

We have no objection to the redefinition of "new starts" to distinquish "expansions" or "conversions" (proposal 2A). We have no objections to higher and different thresholds for "new starts" and "expansions" provided career employees are not displaced or career opportunities are not cut off (proposals 2B and 2C) and that both sides of the equation are treated fairly. We concur that a definition of "conversion" would be helpful (proposal 2D). We interpose no objection to proposal 2E, or to proposal 2F, provided we have an opportunity to comment on the supplements to A-76 addressing the procurement of communications and ADP services, depot maintenance, and research and development work. We have no objection to proposal 2G.

If additional information or clarification is required with respect to any of the above, please do not hesitate to contact the President's Office of AFGE.

STATEMENT OF HON. W. G. "BILL" HEFNER

Mr. Chairman and Members of the Committee, I want to thank you for allowing me to appear before you today to present my views on OMB Circular A-76, "Policies for Acquiring Commercial or Industrial Products and Services Needed by the Government." As a former Member of this Committee, I am well aware of the disasterous effects this Circular could have on the Veterans' Administration's ability to provide quality health care.

The Committee on Veterans' Affairs recognized the potential effects of A-76 when the Subcommittee on Oversight and Investigations held a hearing on VA's implementation of the Circular on July 14, 1981. In response to a question submitted by Chairman Montgomery, the VA indicated that the Office of Management and Budget had requested that the VA conduct A-76 cost comparison studies in three major areas within the Department of Medicine and Surgery. These are hospital food preparation, hospital custodial services and hospital plant maintenance. The VA informed the Chairman that "the entire schedule of A-76 cost comparison review in the VA will involve about 3,880 studies." The VA also stated that "the cost of reviewing the entire VA inventory of commercial and industrial activities to be estimated at $29 million. This figure is based on a period of three staff months for each complete review at a cost of $2,500 per staff month. Using the same assumption, reviewing the three functions given priority by OMB will cost more than $10 million."

Mr. Chairman, initially the Office of Management and Budget advised the VA that the $10 million necessary to conduct the 3,880 studies would have to be absorbed by the Department of Medicine and Surgery, thereby diminishing already tight obligated resources for VA hospital care even further. I am pleased, however, that this Committee had the vision to correct this matter in H.R. 3995, "the Veterans' Disability Compensation, Housing and Memorial Benefits Amendments of 1981." If approved by the President, language contained in H.R. 3995, as amended, will prevent the Veterans' Administration from using funds appropriated for VA medical care, medical and prosthetic research and medical administration and miscellaneous operating expenses for the conduct of certain cost comparison studies regarding the contracting out of functions of the VA's Department of Medicine and Surgery. If the Office of Management and Budget desires that the VA conduct such studies, they will be required to ask for specific appropriations for such purposes instead of taking the funds from the VA's health care delivery account.

I am also concerned that the Office of Management and Budget may be misleading this Committee in its assurances that direct VA health care will not be contracted out. On July 14, 1981 Mr. Don Sowle, Administrator of OMB's Office of Federal Procurement Policy, in response to a question from my colleague, the Honorable Hal Sawyer, stated that OMB was not giving consideration to actually contracting out patient care. However, in response to a written question submitted by Chairman Montgomery subsequent to the July 14th hearing, Mr. Sowle indicated otherwise. I would like to quote the question and response.

Chairman MONTGOMERY. "The OMB, in response to a GAO draft report, stated it would not oppose a joint resolution incorporating the basic policy of OMB Circular A-76 provided it clearly states 'It is the general policy of the government to rely on competitive private enterprise to supply the products and services it needs.' Do you anticipate this to mean OMB would expand A-76 to include direct health care delivery"?

Mr. SOWLE. When published in March, 1976, attachment A to OMB Circular A-76 contained examples of commercial and industrial activities. In the health services area the following items are listed:

Surgical, medical, dental and psychiatric care; hospitalization, outpatient, and nursing care physical examinations; eye and hearing examinations—manufacturing and fitting hearing aids; medical and dental laboratories; dispensaries; preventive medicine; dietary services; and veterinary services.

Unless there is a provision of law or the national security exclusion in Circular A-76 applies precluding consideration of any of these activities, they should be examined for the least expensive mode of performance; i. e., in-house or under contract."

Mr. Chairman, I believe Mr. Sowle has made himself quite clear. Anyone can gather from this response that the Office of Management and Budget does indeed plan to investigate the feasibility of contracting out for direct health care.

OMB Circular A-76 also threatens to hamstring the management of VA hospital directors. With the implementation of A-76, VA hospital directors will be serving intensively as members of ongoing cost review teams for the next two years, and cyclically thereafter. This can only have a damaging effect on managerial productivity in other vital areas of hospital administration. A-76 will also create a new layer

of "supervision", meaning that all coordination, direction and managerial actions must be filtered through the contractor's representative. I believe the hospital director's time can be more effectively utilized for the betterment of veteran patients rather than having to deal with the daily problems of the contract employees. I certainly do not want to see the directors become contract overseers.

Finally, Mr. Chairman, I want to discuss the adverse impact of OMB Circular A–76 on VA hospital employees. It is my understanding that approximately 22,800 loyal VA employees stand to lose their jobs should this Circular be fully implemented. Although these jobs may be classified as non-direct health care, the adverse impact of placing contract personnel in these positions could only hamper the direct health care function of doctors and nurses. The majority of these employees have been on the job for several years, and have become an integral part of the hospitals' delivery of excellent health care. These employees are dedicated to the care of the veteran. This is probably a direct result of most of these employees being veterans themselves; 64 percent or 15,592 of the 22,800 employees who could be displaced are veterans. This Committee and the Veterans' Administration are dedicated in their efforts to assist the veteran in his or her attempt to find employment following their tours of active duty. If we allow these 15,592 veterans to lose their jobs through contracting out, then we have surely failed in that responsibility.

I know from firsthand experience that the employees of the Salisbury, North Carolina VA Medical Center in my Congressional District are providing service in a diligent and cost effective manner. I am not sure that a contract employee will have the same devotion to the VA or to the veterans.

Mr. Chairman, that concludes my statement. I would like to thank you for holding this hearing. I think it is extremely important that the Administration know that we are not going to sit idly by and watch the VA hospital system be diminished by contracting out. The horror stories associated with previous contracting out ventures are too numerous to mention, and the Committee is aware of them. I do not think this Committee will allow these same stories to be told with the veteran as the victim under the latest version of OMB "cost-cutting" efforts under the guise of reducing employment. Federal employment may be reduced, but that doesn't mean we are going to "save" money.

STATEMENT OF CONGRESSMAN HAL DAUB, SECOND DISTRICT OF NEBRASKA

Mr. Chairman, I commend the Committee for presenting this opportunity to members of the House to express their concerns about the application of the Office of Mangement and Budget's circular A–76 to the American veteran's health care delivery system.

The VA medical centers of Nebraska, including the center in Nebraska's Second Congressional District, at Omaha, would be subject to this circular. After careful review of the implications of this circular for the VA, it has become apparent that it violates Title 38 of the U.S. Code. With the Title, Congress expressed its clear intent that the Department of Medicine and Surgery, not OMB, determine the rules and procedures governing our nation's veteran health care system.

Further, U.S. Code Title 38 reserves the authority for contracting out health services to the Department of Medicine and Surgery. The reason why this authority resides in the Department of Medicine and Surgery rather than other entities such as OMB is quite simple; this is where the knowledge and expertise to meet the health needs of veterans resides.

I would urge this Committee to keep in mind that the cost of the proposed feasibility studies is nearly $30 million. As an enthusiastic supporter of budget restraint, I question the wisdom of expending this considerable sum on merely the examination of a proposal of dubious cost-effectiveness.

Finally, while OMB has been quick to advance this circular, it has not been as forthcoming with funds to cover the substantial cost of compliance the VA will undoubtedly incur. The net effect will be a syphoning off of resources from critical health care activities.

Mr. Chairman, this committee and, indeed, the entire House of Representatives has spent countless hours over the years in devising and maintaining a health care system for those who have selflessly served this country often at times of national emergency. For the Veterans center in Omaha and those around the country, this circular threatens to erode the progress that has been made for the men and women who have so generously served our nation.

Mr. Chairman, I respectfully urge an exemption for the VA from this circular.

HOUSE OF REPRESENTATIVES,
Washington, D.C., November 2, 1981.

Hon. G. V. MONTGOMERY,
Chairman, Subcommittee on Oversight and Investigations, House Veterans Affairs Committee, Washington, D.C.

DEAR SONNY: I know that your Subcommittee has been holding hearings on the possible effects of implementation of OMB Circular A-76 on veterans hospitals and patient care.

As you may know, the William S. Middleton Memorial Veterans' Hospital is located in the Second Congressional District of Wisconsin. Over the past few years, I have had ongoing correspondence with members of the staff and numerous patients who are genuinely concerned, not only about lost jobs, but, more importantly, about the negative effect that they feel elimination of in house services will have on patient care.

Recently, I received the enclosed letter from Dr. Francis M. Forster, Director of the Epilepsy Center at the hospital. I think that his comments are well worth the Subcommittee's attention. Would you be good enough to consider them for inclusion in the Subcommittee's record? Thank you for your consideration.

With kind regards,

Sincerely,

ROBERT W. KASTENMEIER,
Member of Congress.

Enclosure.

COMMITTEE ON VETERANS' AFFAIRS,
November 6, 1981.

Hon. ROBERT W. KASTENMEIER,
House of Representatives
Washington, D.C.

DEAR BOB: Thank you for your letter of November 3rd enclosing correspondence from Doctor Francis M. Forster, who is a member of the staff of the William S. Middleton Memorial Veterans' Administration Medical Center.

As requested, Dr. Forster's letter will be made a part of the Committee on Veterans' Affairs October 20, 1981 hearing record.

Best wishes.

Sincerely,

G.V. "SONNY" MONTGOMERY,
Chairman.

WILLIAM S. MIDDLETON MEMORIAL VETERANS' HOSPITAL
Madison, Wis., October 16, 1981.

Hon. ROBERT W. KASTENMEIER,
House of Representatives,
Washington, D.C.

DEAR BOB: I am writing to you regarding the possibility of contracting out certain functions of the VA. It is a position that I am concerned about in at least two aspects.

About the aspect of contracting out certain services pharmacy plays a particularly critical role and has been extremely helpful in the sorting out of certain problems. They have a certain expertise that would not be available in a routine pharmacy service. Also, they have been particularly helpful in my field in solving problems of the precipitating factors in epilepsy by preparing double blind studies for me to determine possible substances that may have provoked a seizure in a particular patient, i.e. the taking of a phenothiazine. They assist with determining whether a scientific procedure could be carried out to determine whether a patient's seizures are due to a particular cause.

Dietetics likewise has been a particular help. For example, we have had patients with conditions like "hot dog migraine" due to nitrites; they help us in proving it and also in giving the patient a diet which would avoid this. Other examples are helping in the special treatment of patients with cardinoid and the devising of particular diets for them.

Engineering, because of the special equipment here—electronics, etc.—is of special importance in the laboratory for the diagnosis and treatment of epilepsy.

For these reasons I would be very grateful to you if you would give consideration to not having these services jobbed out.

Cordially yours,

FRANCIS M. FORSTER, M.D.,
Director, Epilepsy Center 6B.

STATEMENT OF REPRESENTATIVE CLEMENT J. ZABLOCKI

Mr. Chairman, it is a privilege for me to submit this statement on the very serious issue of the implementation of the Office of Management and Budget Circular A-76 at the Veterans Administration. Let me commend you, Mr. Chairman, for initiating these hearings as part of the ongoing investigation of the Subcommittee into the very grave effects of contracting out, particularly in the Department of Medicine and Surgery at the Veterans Administration.

As you know, Mr. Chairman, OMB's Circular A-76 "Policies for Acquiring Commercial or Industrial Products and Services Needed by the Government" directs the VA to study the feasibility of using private contractors for certain work rather than federal workers. Fortunately, because of the recent efforts of your Subcommittee and the Senate Veterans Affairs Committee, it is my understanding that already appropriated VA funds may not be used for A-76 studies. However, like you, my position is that the question of contracting out at the Department of Medicine and Surgery is a long-range issue and one that should be resolved once and for all.

Mr. Chairman, I am opposed to the use of private contractors at VA hospitals for two reasons. First, VA hospitals are not directly comparable to other federal agencies. While contracting-out may be acceptable at other federal agencies, the unique service of the VA Department of Medicine and Surgery is that it provides a basic health care to individuals. The quality of patient care is of the highest standard and should remain so. I question the wisdom of contracting-out services at a hospital under the assumption that the quality of care will not be lessened.

Second, I oppose contracting-out services in DM&S because of its devastating impact on jobs, most of which are held by veterans, minorities and blue-collar workers. As you know, the implementation of OMB Circular A-76 at VA hospitals nationally is expected to eliminate the jobs of an estimated 22,000 VA hospital employees.

Mr. Chairman, I would like to elaborate on these two points. OMB argues that private contractors should be used by agencies when it appears that they will be cost-effective. In some cases, this may be a perfectly valid argument. However, I must point out that several years ago at a VA facility, laundry services were contracted out at what appeared to be a lesser cost. Not only did the cost go up after the initial contract was awarded, but quality of service and delivery shortly lessened, and the facility soon returned to the use of in-house employees.

OMB argues that no direct patient care jobs are scheduled for possible contracting out. But anyone who has been in a hospital knows the importance of good food, cleanliness and a well-maintained environment. Under the OMB directive, it is conceivable that a dietitian could order a special meal for a patient and an outside catering service would prepare it. Not only would the dietitian lose control over the meal service but there would always be the question of timely delivery by the outside company. If, because of human error or natural occurrence, e.g., the weather or transportation problems, unquestionably the health care service could be jeopardized.

With respect to the question of jobs, my position, Mr. Chairman, is that this is a grave area of concern. The 22,000 jobs in jeopardy at the VA hospitals are maintenance personnel, cooks, dishwashers, trade and craftsworkers, and cleaning people. Almost all of these jobs that are targeted by OMB are held by blue-collar workers, including veterans. It is important that we look closely at who exactly is going to be hurt by contracting-out at DM&S. It is not primarily the government bureaucrat but the manual worker, including veterans and minorities.

Interestingly, in the last two decades, the government blue-collar workforce has shrunk by over 200,000 slots while white-collar positions have risen by 300,000. I question the wisdom of again forcing the "little guy" to bear the burdens of an inflationary society and poor economy by asking him to give up his job.

At the Wood, Wisconsin facility, any contracting-out of positions in food preparation, custodial services, and plant maintenance would affect about 500 jobs. It is worth noting that of the 104 full-time jobs in plant maintenance—carpenters, painters, electricians, general labor—close to 90 percent are veterans; of the 250 food service workers—cooks, food tray deliverers, clean-up crews—55 percent are minorities. To ask these individuals to give up their jobs is, in my opinion, an unwarrant-

ed burden to place on individuals at Wood, under the guise of OMB's budget cutting efforts.

Finally, Mr. Chairman, as you pointed out in your September 21 letter to me, the A-76 cost comparison studies on plant maintenance, food service and custodial services required by OMB will cost the VA approximately $10 million and the total effort will cost $29.1 million. These figures in view of the current philosophy of this Administration are, in my opinion, astronomical. Surely $29.1 million could be better used to provide services to veterans.

Because I have yet to be convinced that such efforts will do anything to maintain the high level of care at the VA hospitals or to realistically save money when one considers the cost to society of providing benefits to over 22,000 displaced workers, let me restate my opposition to contracting-out services at the VA hospitals.

Thank you, Mr. Chairman, for affording me the opportunity to submit this statement. Your efforts to maintain the integrity of the VA hospitals in meeting their commitments to our veterans and federal employees are commendable. I will be happy to continue working with you on this most pressing issue.

STATEMENT OF HON. CHARLIE ROSE

Mr. Chairman, I want to thank you for giving me this opportunity to share with your Subcommittee some of the experiences I've had with contracting out in my district. I have two bases in my district where the Federal Government has been actively pursuing this policy, Fort Bragg and the Military Ocean Terminal at Sunny Point.

I have been interested in this topic for a long time. Three years ago I held hearings in Fayetteville at which government employees testified, and I have continued to follow the developments in this area very closely.

The basic idea behind OMB Circular A-76, the attempt to save the government money, is admirable. However, I feel strongly that it is misguided. Comparing the cost of any work-function using government workers versus outside personnel is like comparing apples and oranges because the government has little control over future contractor employee benefits. The initial first year cost may seem to be less, but once the government employees have been dismissed and their work space reassigned, the contractor no longer has the same incentive to keep his costs low.

Even the costs of the first year may be more than the original contract due to cost overruns (because the original estimate was too low) and/or to poor performance. A good example of the latter occured at Fort Bragg in relation to a Janitorial Service contract. I have been told that complaints had to be continuously filed because the rest rooms were not kept clean, even though the contract specified that they be cleaned twice a week. I understand the government employees often cleaned them themselves, adding to the actual cost of doing this work. The contract was terminated and relet, but the original contractor is now suing, which further increases the federal costs.

This fear of being sued for contract termination sometimes prevents the government from changing contract specifications to meet changing requirements. Another contract at Fort Bragg was brought to my attention to paint wooden window trim. Before this contract was completed, an energy conservation policy was initiated, and so new storm windows were ordered. I'm told that instead of terminating the painting contract, the government waited until it was finished and then replaced much of the wooden trim with storm windows.

In some instances, poor contract performance can endanger individual lives and conceivably our national security. I was told that a routine maintenance check-up of a U.S. Army Readiness Command U-8 Aircraft revealed that a wire was severed and taped up which was necessary to alert the pilot of a serious malfunction. This wire was adjacent to new wiring that a contractor had installed only 10 hours earlier. I understand that the cost to the government to find and repair this problem was 20 manhours, but it could have easily been a plane crash with lives lost.

I'd like to quote from a letter I received from the Fort Bragg AFGE to give you a last example of contract abuse; it refers to a contract modifying Army CH-47 Helicopters:

"It seems that a portion of the subject contract requires the payment of about $64 per person in per diem expenses to contractor employees who perform the modification work if they remain at Fort Bragg for something under 30 days. Interestingly enough, the contractor employees have consistently been rotated at a point in time that mandates continuing payment of the per diem expenses!

"Manipulation of contract terms to the expense of the government, and therefore the taxpaying public, is the rule not the exception in Federal contracting actions, especially in high-technology defense-related services."

In summary, I want to ask you, Mr. Chairman, and your Subcommittee to closely scrutinize and question the Administration's drive to have as many functions as possible contracted out. I feel that it would also be beneficial to take a close look at contracts which are already let out to insure that they are performing well. Occasionally, the government itself acknowledges that a task can be better performed by permanent employees as it did when it brought a railroad function within house after contracting it out for over 20 years; as a result, Sunny Point is now saving $300,000 a year. I feel sure if the costs of other contracts were honestly looked at that many more could by done by government employees.

STATEMENT OF CHARLES E. JOECKEL, JR., DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Chairman and members of the committee, on behalf of the nearly 700,000 members of the Disabled American Veterans, I am pleased to appear here today, Mr. Chairman, to discuss the impact of the implementation of the Office of Management and Budget Circular A-76.

Let me begin by expressing to you and the members of this Committee our sincere gratitude for your efforts to insure that the funds required to conduct cost comparison studies relating to the OMB Circular A-76 are not taken from certain VA health care accounts. I refer, of course, to the House initiative contained in S. 917 which was retained at your insistence in the compromise version of the bill.

As you know, Mr. Chairman, recognizing that the private enterprise system is the primary source of our national economic strength, it has been the policy of the government for quite some time to rely upon competitive private enterprise to supply the government with products and services. Such a policy was first recognized as early as 1955 and in March 1966 Circular A-76 was issued for the first time.

So the concept of government reliance on the private sector for goods and services is nothing new. What is new, Mr. Chairman, is the fact that the current revision of OMB Circular A-76 proposes to contract to private enterprise nearly every facet of maintenance and service presently performed by federal employees.

It is interesting to note that the current revision of Circular A-76 points out in its background material that the federal government should not place itself in the position of competing with private enterprise. In general, we concur in this assessment.

However, we contend that in terms of veterans' benefits and services—particularly in the area of health care—our programs have never been a part of the private enterprise market. Since World War II, at least, veterans' health care, for example, has been provided exclusively by the government through a federally owned and operated health care system.

It can be said then that veterans' health care has not been, over the years, a market which has been stolen away from the private sector. Further, in our view, there is no competing interest in the private sector which seeks to provide medical care to all current eligible veterans at a cost equal to or lower than that presently provided through VA's system of hospitals and outpatient clinics.

In this connection, Mr. Chairman, I would like to point out that last summer the Veterans Administration completed a study which showed that VA medical care is 18.3 to 22.5 percent less expensive than similar care provided by comparable private health care facilities. According to this study, it would have cost American taxpayers nearly one half billion dollars more to send eligible veterans to private health care facilities. Further, care at a VA hospital for an average medical episode last year cost $2,480. The same care extended in a community hospital would have cost $2,981—over $500 more. The average episode of surgical treatment in the VA last year cost $3,255 while the same care at a non-VA facility would have cost $4,061—over $800 more.

OMB Circular A-76 seems to assume that outside contractors would provide the same quality of work as VA employees. However, part of the reason, in our view, that VA medical care costs less, rests with the fact that its services are provided in-house by the thousands of dedicated federal employees who have at heart a genuine interest in the welfare of veterans. What price can be placed upon the dedication demonstrated daily by VA personnel?

At the center of the controversy—regarding VA health care, at least—is an issue solely related to rising federal expenditures and health care costs. We have already

demonstrated that medical care provided by the VA is cost effective. But, there are other considerations—I alluded to one a moment ago, dedication.

Permit me to discuss some of the others, Mr. Chairman.

STRIKES

What would happen if a VA hospital contracted out for some essential service—food preparation, for example—and the contractor's employees decided to strike? Such a job action could bring a VA medical facility to its knees, possibly forcing the facility to close until the contractor settled the employee dispute.

POOR QUALITY WORK

What would happen if a company under VA contract did poor quality work? As you know, Mr. Chairman, firing a company that holds a contract with the federal government can be a long, drawn out, expensive process. VA hospital administrators could easily be forced to put up with inferior work until the contract runs out.

INCREASED COST

What happens when a contractor submits a short-term, undercutting bid against which VA employees cannot compete? The contractor could take his losses during the first Fiscal Year and, when the VA has lost its ability to handle the work in-house, the contractor could demand an increase in the price of the contracted services.

MANAGEMENT CONTROL

Difficulties with contractors is not the only problem VA officials would be faced with. Implementation of OMB Circular A-76 would fragment the management of the VA health care system. Each time another service is contracted out, hospital administrators would lose that much more control over the operation of the facility.

Management of individual hospitals and of the system as a whole would become incredibly complex. A new layer of VA management would be needed to negotiate contracts, coordinate the activities of contractors and make sure employees of the contractors are getting the job done.

Carried to its extreme, OMB Circular A-76 could force the VA to contract whole hospitals for the care and treatment of veterans. Then, what kind of control would the agency have over the quality of care provided to veterans?

Mr. Chairman, although the VA has had only limited experience with the contracting out of its services, some of the problems I have just referred to have already occurred in the VA.

For example, here is what happened at the VA Medical Center at Cheyenne, Wyoming. The Veterans Administration contracted with a service to clean its laundry. The linen wasn't cleaned well enough, it wasn't delivered on time, and less linen was coming back to the medical facility than was being sent out. Finally, the Medical Center terminated its contract with the private firm and now it sends its linen to the VA Medical Center in Denver for laundering.

The VA Medical Center in Reno, Nevada was sending its laundry to a sole-source contractor until the contractor increased the price of services by some 700 percent. In addition, the Reno medical facility had to pay out $80,000 to replace linen and other laundry items that had turned up missing or were not returned from the laundry on time. This VA facility is now having its laundry done in Sacramento, California.

The Administration insists that its program to curtail federal spending, as well as, its intention with respect to OMB Circular A-76, will not interfere with direct patient care. However, Mr. Chairman, if the VA contracts its health care services to the degree proposed in A-76, it will, in our view, have a direct adverse impact on the health care provided to veterans.

You simply cannot operate a hospital with direct health care personnel alone. Every service plays a significant role in carrying out its mission of providing for the adequate care and treatment of veteran patients.

Recognizing this, the delegates to our most recent National Convention held last July adopted Resolution No. 528 opposing the contracting out of services in VA health care facilities. The resolution states in part that the Disabled American Veterans . . . seeks the enactment of legislation which would grant to the VA's Department of Medicine and Surgery an exemption to the provisions of the Office of Management and Budget's Circular A-76.

This concludes my statement, Mr. Chairman, and I wish to again thank you and the members of the Committee for giving us this opportunity to express our views on this important subject.

COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C., November 5, 1981.

Mr. JOHN J. SWEENEY,
International President, Committee on Political Education, Service Employees International Union, Washington, D.C.

Dear MR. SWEENEY: Thank you for your recent letter concerning the opposition of the Service Employees International Union to the provisions of OMB Circular A-76.

I will be happy to include your letter as part of the Record of the hearings our Committee held recently during which we received testimony from many VA employees in the field on the impact of contracting out for various services within the Department of Medicine and Surgery. You may be aware that a provision of Public Law 97-66 would prohibit the use of medical care, medical and prosthetic research and medical administration and miscellaneous operating expense funds to conduct the cost studies mandated by the Office of Management and Budget.

The testimony presented by the Veterans Administration and the Office of Management and Budget at that hearing confirmed that no further studies could be made until funds could be specifically appropriated for that purpose. I think there is little chance that will be done. I certainly intend to protect the integrity of the Department of Medicine and Surgery, and should serious efforts be made to mandate that contracting out be conducted in the future, I am certain the members of our Committee would consider legislation to prohibit such activities.

Sincerely,

G. V. "SONNY" MONTGOMERY,
Chairman.

COMMITTEE ON POLITICAL EDUCATION,
SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO/CLC,
Washington, D.C., October 23, 1981.

Representative G. V. MONTGOMERY,
Chairman of the Committee of Veterans' Affairs, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: The Service Employees International Union represents 16 Veterans Administration's installations throughout the country, and in these hospitals and other facilities, we represent approximately 12,000 workers in housekeeping and food service. We believe that contracting out of these services by the Veterans Administration would be seriously harmful to good patient care in the V.A.

We hope that you will see fit to make recommendations against the contracting out of these services. Most of our local unions in their negotiations in the past have never reflected on the possibility of contracting out of hospital services in the V.A. However, one local union, SEIU Local 200, concluded a contract with the V.A. on November 18, 1977, which included the following clause:

"Article 16. Changes—Automation and Technological: Where automation, technological change or the introduction of contractual services serve to significantly eliminate duties, functions or positions of employees in the unit, every reasonable effort will be made by the Employer to reassign employees affected to other continuing positions, or, where feasible, to retain such employees for a continuing position in the Hospital at a salary equal to, or as near as possible to, the employee's current salary as permitted by V.A. and Civil Service regulations."

Would you please include this letter as part of the official hearings of your committee on this subject.

Sincerely yours,

JOHN J. SWEENEY,
International President.

STATEMENT OF STANLEY Q. LYMAN, EXECUTIVE VICE-PRESIDENT OF THE NATIONAL ASSOCIATION OF GOVERNMENT EMPLOYEES

The National Association of Government Employees (NAGE) is grateful for the opportunity to present its views on the implementation of OMB Circular A-76 by the Veterans Administration to the House Committee on Veterans Affairs. We commend the chairman and the committee for focusing national attention on the

problems associated with contracting out in the Veterans Administration. It is our hope that through these efforts, the American people will come to realize the danger which contracting out presents to the accomplishment of the mission of the Veterans Administration.

NAGE represents over 15,000 employees in the Veterans Administration and has long been opposed to wasteful, costly and unnecessary contracting out of government services. The evidence available at this time suggests that contracting out has cost the American taxpayers millions of dollars, has created enormous obstacles to accomplishing the missions of government, and has damaged morale in government to a dangerous extent. The evidence has not established that contracting out is a less costly way of accomplishing the aims of government as is suggested by its proponents.

Indeed, the General Accounting Office in a report issued on March 20, 1980, was roundly critical of the policies and practices of Federal agencies in contracting out. The GAO stated that agency contracting practices had led to inefficient use of money and personnel, and a lack of agency control over the project. It was further noted that guidance provided by OMB in 1978 had led to little substantive improvement.

Despite all these concerns, the Federal government's policy on contracting out has led to the growth of huge shadow government. In the last decade, outlays for grants and contracts has grown astronomically, while at the same time, the number of official government employees has actually decreased. The number of employees under contract now exceeds civil service employes by over 70 percent.

The history of contracting out tells us that many agencies will contract out services which are unnecessary or could be more efficiently or effectively accomplished by in-house personnel. The considerable problems which arose with contracting out led OMB to revise Circular A-76 in March 1979. This revision established procedures for determining when a function should be performed in-house by government employees and when it should be carried out under contract. However, the revised Circular A-76 has failed to provide adequate Federal guidelines on contracting out. This new document has failed to prevent the growth of this mammoth body of contracted employees, nor has it led to a more cost effective government as a result.

One of the primarily reasons for the enormous growth of contracting out is the stated bias favoring contracting out which is prevalent in Circular A-76. The Circular skews the requirement for cost comparison and calculation in favor of contracting out. This bias in favor of contracting out is shown by the fact that several contract related expenses are not even addressed. The Circular fails to factor the expense of unemployment payments, saved pay requirements, and placement and training programs for displaced civil servants. Nor does the cost calculation consider the effect on employee morale, and lessened productivity resulting from large scale reductions in force.

Several specific advantages are given to contractors in the cicular's provisions for cost comparisons. The methods of factoring in Federal retirement costs are blatantly unfair. In-house retirement costs are based on future as well as "length of contract" retirement costs. There is no equity in using a 20.4 percent of salary figure for in-house retirement costs when contractors are not required to use "dynamic normal cost projection" for figuring their retirement costs.

In addition, the Circular's provision for insuring cost comparisons based on efficient government operations of activities is particularly inadequate. Section 9.c.(1) reads: "Each agency should assure that Government operations are organized and staffed for the most efficient performance. To the extent practicable and in accordance with agency manpower and personnel regulations, agencies should precede reviews under this Circular with internal management reviews and reorganizations for accomplishing the work more efficiently, when feasible." There are too many qualifying phrases in the above provision. Further, given the inadequate enforcement provisions of the Circular, the above quoted provision has often been ignored by agencies which find it easier, even if ultimately more costly, to contract out work instead of tightening up their own operations. The victims in this scenario has been the American taxpayer who pays the unnecessary costs, and the patients of the Veterans Administration, who receive a lesser quality of services.

One of the most significant biases toward contracting-out reflected in Circular A-76 is the exemption from required cost comparisons of activities estimated at an annual cost of less than $100,000. The revision of Circular A-76 raised the threshold for requiring cost comparisons by 100 percent: from $50,000 to $100,000. This provision, 9.a.(5), would exclude too many contracting decisions from cost comparisons.

In addition, it appears that agencies can divide an activity for contracting so that no contract is over the threshold. Such practices would save agencies the trouble of

making cost comparisons. However, the American taxpayer, who ultimately pays for costly contracts, will have to foot the bill.

Section 9.a.(5) further provides that: "... Activities below this threshold $100,000), should be performed by contract unless in-house performance is justified in accordance with paragraph i.a. (Government Operation of Commercial or Industrial Activities: No Satisfactory Commercial Source Available) or 8.b. (National Defense.)" Amazingly, this provision does not even mention higher cost. Thus, not only are activities below the threshold exempt from cost comparisons, but they are also eligible for contracting-out regardless of expense. The revised guidelines give agencies carte blanche to engage in contracts under $100,000.

Past experience tells us that agencies will take full advantage of this freedom to engage in costly contracts. The following is an example of the kind of abuse of sound fiscal principles that can be expected. The Langley Air Force Base in Virginia signed a contract with a private firm for painting the boiler room. The contract costs over $40,000. However, because the contract fell below the $50,000 threshold for requiring cost comparisons, no study was made of the in-house cost of doing the job. The NAGE understands that the job could have been done in-house for $16,000 to $20,000. That is less than half the contract cost! This one example may sound miniscule when compared to an over $500 billion Federal Budget, but it is indicative of the kind of irresponsible decision making that leads to excessive government spending and thus high taxes. Raising the threshold for cost comparisons to $100,000 will only provide more opportunities for abusing federal monies.

Another glaring bias is the clearly deficient cost comparison requirement for contracts up for review. Under the guidelines, once contracts have been entered into, agencies have very little incentive to end them. The provision for the review of contracts, 10.c.(2) reads: "... The agency will review the contract cost and determine whether it is likely that the work can be performed in-house at a cost that is less than contract performance.... When this is determined to be likely, a cost comparison will be conducted." (Emphasis added). In other words, agencies are not required to run cost comparisons during reviews of contracts unless the savings to be accrued through in-house operation are quite obvious.

NAGE finds the deficiency of the above requirement deplorable because recent pay caps mean that in-house operation of many activities may now be more cost advantageous than current contracts. It is unconscionable that Federal employees should have to suffer the effects of mandatory pay raise caps of 5.5 percent in fiscal year 1979 and 7 percent in fiscal year 1980 and 4.8 percent in fiscal year 1981, then not reap the benefits of job security that would come from bringing contracted activities back in-house.

The evidence thus far has indicated that contractors tend to bid low in the first year. In subsequent years, the contractor is aware that administrators have no ability to reconvert the activity into an in-house operation since personnel slots are scarcer than dollars. The contractor is able to capitalize on the position he has the agency in, to extract exorbitant profit. A study done by the Department of the Army for the Health Service Command on the change in 23 custodial contracts at medical facilities from the first to the second year of the contract demonstrated a twenty-five (25) percent average increase in the cost of the contract. This increase was three or four times the rate of inflation at the time the study was done.

Not only are the guidelines biased toward contracting-out in the area of cost comparison, but the Circular is also deficient in the enforcement area. NAGE is appalled at the lack of checks and balances on contracting-out decisions. The appeals provided for in the revised Circular are so limited that interested parties may not be able to stop a particular contract on the basis of excessive cost or a violation of the guidelines.

The Office of Federal Procurement Policy (OFPP), under OMB, has the authority only to review agencies' internal instructions and appeals procedures. The OFPP cannot review actual contracting-out decisions. The appeals procedures set forth in Circular A-76 does not authorize appeals outside the contracting agency. Agency determinations are not subject to negotiation, arbitration, or agreement. Even judicial review is prohibited. Appeals are only possible within the contracting agency, and the decisions of that agency are final. Yet, officials within the contracting agency cannot possibly make impartial judgmer.

The need for a substantially improved system of appeals on contracting-out decisions is dramatically illustrated by the fact that NAGE was unable to prevent a contract that is causing the needless expenditure of over $2 million. In fall 1978, the Federal Aviation Administration (FAA) contracted with the Rockwell Company for the modification of 19 FAA Saberliner Aircraft. This work could easily be accomplished at the FAA's Air Service Base in Oklahoma City, Oklahoma, in nearly one-third less time at a savings of approximately $104,042 per aircraft for a total savings

of about $2,000,000. Despite the protests of NAGE and the Director of the Air Service Base, the bureaucracy within the FAA in Washington authorized and signed the Rockwell contract. This example clearly demonstrates that contracting-out decisions should be appealable to an independent party. The NAGE firmly believes that contracting-out decisions are of such significant that judicial review is warranted.

The revised OMB Circular has failed to eliminate the abuses of contracting-out. Indeed, the baised regulations concerning cost comparisons and inadequate provisions for reviewing contracts and appealing decisions has created a situation where graft and corruption in the award and administration of the contract can flourish. It is tragic to think that the quality of services provided to veterans could be diminished for this reason.

The issue in contracting-out is not solely one of cost effectiveness. Even if private industry is at times more efficient, can government afford to relinquish part of its control over the function, and abdicate that responsibility to private industry? NAGE believes that government should not relinquish its responsibilities to its veterans but rather should work to improve the efficiency and effectiveness of government services provided. It is suggested that the loyality and dedication of career federal employees is more productive in servicing the needs of veterans than are private contractors whose motive is mere profit.

The Veterans Administration's mission of caring for veterans can more comprehensively be accomplished by a career federal employee, whether he be professional or blue collar, who has been instructed by hospital policy and regulation on the needs of the patient, and is willing to undertake that extra effort to support the agency's mission. The officials of NAGE have long been impressed by the dedication of VA workers in this regard.

When government functions are performed by government employees, the government retains managerial control of the employees and their work output. Government employees must maintain an acceptable level of job performance to qualify for within-grade salary increases, and employees who consistently perform at a less than acceptable level of job performance do not remain in their jobs. Management thus has tools to control and motivate the job performance of federal employees.

When work is performed by a private contractor, these management tools are not available. Employees of the private contractor are not subject to the federal personnel laws and regulations, and are not under the managerial control of government employees. In fact, Circular A-76 specifically prohibits the establishment of an employer—employee relationship between the government and contracted personnel. Section 6-D(2) of the circular reads. "This circular will not be used as authority to enter into contracts which establish a situation tantamount to an employer-employee relationship between the government and contacted personnel. . . . Consequently control of government operations cannot be as thorough as the control to federal government can keep on it's own operation.

One of the most significant distinctions between the laws applicable to Federal employees versus those applying to private employees is the right to strike. The Civil Service Reform Act of 1978 did not give Federal employees the right to strike. Strikes are permissible under the National Labor Relations Act. The policies set forth under Circular A-76 fail to give agencies the freedom to reject a contract bid based on the possibility of a strike by contract employees. Section 8.1(3)(d) reads: "The fact . . . that there is a possibility of a strike by contract employees is not an adequate justification for in-house performance of that activity. Urgency by itself is not an adequate reason for starting or continuing a Government commercial or industrial activity. . . ." Consequently, under the new guidelines an agency could be forced to contract for products and services that would be delayed and even stopped due to job actions taken by private employees.

The contracting out of services is often a mask for a reduction in the level of services, which often could not be accomplished legislatively. Contractors are able to present the agency with an attractive package of cost reduction by reducing the level of services. Inadequate investigation of the statement of work by the agency allows the contractor to achieve this result. In the interwoven environment of a veterans hospital any reduction in support on related services will have a domino effect impacting on patient care.

Many employees of the veterans administrations are themselves veterans hired pursuant to veterans preference consideration. A reduction in force will impact on the level of veterans employed in the agency, and put many veterans in unemployment lines.

The government's mandate to serve the public is not fulfilled when the wasteful, and capricious contracting out of it's functions lessens its efficiency unnecessarily using more of the public's tax dollar to provide them with less service. The Government exists to serve the public. When contracting out serves to undermine that

purpose by reducing the government's effectiveness, and increasing it's cost, it is time to drastically alter it's thinking in relation to contracting out. The criteria currently used to determine whether or not to retain a particular function in house harms the government, it's employees and the people it serves. The National Association of Government Employees urges this committee to consider legislation which would require that Veterans Administration give appropriate weight to the conditions outlined in our statement and control the growth of services contracted out by the Veterans Administration.

WRITTEN COMMITTEE QUESTIONS TO OMB

Responses by Donald E. Sowle, Administrator, Office of Federal Procurement Policy

Question 1. Is the White House mess operated by in-house personnel or is the mess operation contracted to the private sector?

Answer. The White House mess is operated by the Department of Defense and is subject to the provisions of the Circular as implemented by DOD.

Question 2. Does the Office of Management and Budget contract under the provisions of Circular A-76 for audiovisual products and services, automatic data processing, custodial and janitorial services, printing and reproduction or office services.

Question 3. If none of the services listed above are contracted at the present time, which of the services are presently being studied or considered for possible A-76 cost comparison studies?

Answer (2 and 3). OMB obtains audiovisual products and services from the Office of Administration (OA) in the Executive Office of the President. OA has identified this as a commercial or industrial type activity and has scheduled it for review. OMB also obtains automatic data processing (ADP) from OA. OA contracts for 90 percent of the ADP services, and has scheduled the in-house portion for review. Custodial and janitorial services are obtained from GSA, which contracts for the services.

WRITTEN COMMITTEE QUESTIONS TO VETERANS' ADMINISTRATION

Responses by Clyde C. Cook, Assistant Deputy Administrator for Procurement and Supply

Question 1. Presently, VA employees are on duty 24 hours a day to take care of any breakdown in life-sustaining equipment. In the event of the implementation of OMB Circular A-76, what happens when something breaks down? Will the contractor be required to have repairment available 24 hours a day or will the VA have to call the contractor and just wait until he sends someone?

Answer. Our contemplated implementation of OMB Circular A-76 did not include cost comparison studies of our biomedical engineering repair, maintenance and inspection functions. As of the passage of Public Law 97-66, we had considered the repair of biomedical equipment so critical that we considered it necessary to retain management of the function on other than merely a cost basis. However, as presented to the Committee in my formal testimony, we already contract for 50 percent of our biomedical function. The flexibility of retaining the other 50 percent in house ensures the availability of emergency repairs.

There are other plant maintenance functions (boiler plant operations, air conditioning, electrical systems and plumbing), which we had scheduled for cost comparison review. However, for these critical functions we had intended to retain an emergency core of engineering employees who could perform emergency service.

In the event that we were to contract the entire biomedical repair function or the entire plant maintenance function, our contracts would require emergency on-call service or, where needed, 24 hours on duty service. Such capability would be a major factor in assessing bidder responsibility. Some of our current service contracts such as elevator maintenance currently require emergency response time frames.

Question 2. The Committee has been informed that some managerial positions—partcularly those associated with dietetics, building management and engineering services—may be negatively affected by the conversion of "in-house" activities to contracts because position classification is based somewhat on numbers of employees supervised. Can you provide the Committee with an analysis of the projected grade impact on the management and supervisory staff of these 3 functions, as well as any indirect impact on managers in personnel and fiscal services?

Answer. We do not have a projected grade impact for our supervisors in Services for which contracting out might impact. Officials in our Personnel Services indicate, however, that reclassification of such supervisors might result in downgradings unless their new oversight "quality assurance evaluators" (QAE) responsibilities compensate for lessened direct supervisory controls. Their general belief is that contracting out would result in such downgradings.

Contracting out would initially require an increased Personnel Service role due to the RIF process. However, in the long run the fewer VA employee needs would lessen Personnel Service workload. With regard to Fiscal Service, the lessened payroll requirements might have a minor impact on workload.

Question 3. Some VA Medical Centers have commenced advertising for potential A-76 contracts. Will such activity cease and will previous advertisements be cancelled since the enactment of Public Law 97-66?

Answer. In order to comply with Public Law 97-66, our medical centers will cancel current DM&S A-76 studies initiated prior to passage of the law and will not initiate further A-76 studies unless specifically directed.

RESPONSES BY DR. DONALD L. CUSTIS, CHIEF MEDICAL DIRECTOR

Question 1. How easily would smaller medical centers, such as Grand Junction, Iron Mountain, and Big Spring, be able to function with contract plant maintenance? Do you believe you can acquire by contract the necessary engineering coverage: electrical, water, etc.?

Answer. We believe A-76 plant maintenance contracts will create some problems for medical center management, particularly in smaller facilities. We expect that, smaller medical centers will probably attract smaller businesses. It will be more difficult to determine small businesses' financial capability to perform. This determination must be made by the Small Business Administration. Failure of one of these businesses could cause severe problems. In smaller medical centers, Engineering Service employees serve often in multi-faceted positions, with much integration of functions. Implementing a contract for only a portion of these functions will require management to reorganize Engineering staff. In many instances such reorganizations would not be practical or feasible, given the relatively small number of employees available.

Question 2. Do you have any data or other information on the success or failure of service contracting by private sector health care facilities?

Answer. We have not conducted a formal study on this issue. There are indications that the contracting trend may be waning in the private sector. For example, both the University of Michigan Hospital and the University of North Carolina Hospital recently terminated their contracts for hospital housekeeping. Also, a study which appeared in the July 1981 Journal of the American Hospital Association cited a large number of hospitals of all sizes and categories which had returned the housekeeping function to a staff operation.

Question 3. If two or three major VA services are contracted out, such as food service and hospital housekeeping, what problems will be created for your own security staff?

Answer. We suspect the physical security problems which we now combat may increase appreciably if contract workers are permitted to come in, since we will be unable to effectively screen the backgrounds of contract workers. We cannot be assured that they do not have criminal records. With VA workers we do this quite readily, since we are responsible for our own hiring decisions.

Question 4. When private facilities seem content to contract our laundry services, why does DM&S resist? What has been your recent experience with contract laundry services?

Answer. We have had very negative experiences with contract laundries in New York in the late 1950's and more recently in San Antonio, Texas and Reno, Nevada. In those cases, we found ourselves, at the time of contract renewal, in a very unfavorable position. In one case, the contract price escalated 700 percent, and we were without a readily available alternative to meet this vital need. This is one of the reasons we are greatly concerned about utilizing commercial laundries.

RESPONSES BY MARJORIE QUANDT, ASSISTANT CHIEF MEDICAL DIRECTOR FOR ADMINISTRATION

Question 1. Aside from those "commercial/industrial type activities" you have identified in your inventory thus far, the Committee believes there are many more service type functions in VA medical centers to which the A-76 directive could

apply. What are your plans to identify, inventory and review such functions under A-76?

Answer. At this time, the VA has no plan to identify additional DM&S functions for review under OMB Circular A-76.

Question 2. The VA held two national seminars to instruct its personnel on how to conduct the A-76 cost comparison studies. How much did it cost the VA to instruct these personnel, both monetarily and in staff hours? Also, please advise the Committee of the travel costs as well as the total expense. Does the VA plan any similar training sessions?

Answer. The estimated costs for these two training sessions were as follows:

Travel cost	$385,000
Salaries	362,000
Preparation time	10,000
Reproduction/handouts	3,000
Estimated total	757,000

Also, several DM&S medical districts conducted follow-up training sessions to further disseminate the information local managers and executives had received at the two major training sessions. We are unable to estimate these associated costs.

The DM&S plans no further training on the implementation of OMB Circular A-76, in observance of PL 97-66, Section 601.

RESPONSES BY JESSE P. CLEVELAND, CHIEF, BUILDING MANAGEMENT, VETERANS' ADMINISTRATION MEDICAL CENTER

Question 1. Infection control in VA Medical Centers must be one of your major concerns, since the Building Management Service is directly responsible for the facility cleanliness. In your view, how will A-76 affect the environmental sanitation program, especially as it concerns infection control?

Answer. Infection control is a multidisciplinary program wherein many officials are charged with the responsibility, among others, of reducing loss of life and undue suffering by carefully monitoring and controlling cross infections. Under existing conditions, this is a complicated process. To bring in an outside sanitation contractor, with the resultant loss of accountability and addition of another discipline to the infection control process, would compound the present difficulties. Many specific problems could be resolved successfully by negotiation of Medical Center management with the contractor as long as the VA Medical Center retains a qualified environmental sanitation representative. Retention of this individual is doubtful under A-76 in my opinion. And if the VA Medical Center does not have a qualified environmental sanitation representative, response to new problems, adoption of new procedures and implementation of these new procedures would not be "all in a day's work" as currently exists.

As I stated in my oral response to a question at the hearings of October 20, 1981, Building Management officers are in the hospital sanitation business and are highly qualified, and as such will be competitive with outside contractors if the cost comparison process is implemented. This factor alone will reduce the effectiveness of the sanitation program irregardless of whether the function is actually contracted out or not.

It has been established, and I agree, that the key to an effective and efficient contract is the preparation and monitoring of the statement of work. I have heard testimony to the effect that Building Management officers are qualified to prepare and monitor these statements of work. I do not have this same confidence. Engineering Service does most of the contracting out of services at Medical Centers at present. Therefore, the Chief Engineers at facilities have more expertise in specifying for contract work. In many cases such as maintenance of elevators and other equipment, they have been highly successful. However, in the area of construction work, the record leaves much to be desired. Cost overruns, exceeding of completion dates, instances of litigation, amendments of contracts, etc., are common place. I, and my peers, are managers of people and programs, not contract specifiers or contract monitors. Again, I can only foresee a diminution of efficiency and effectiveness, and a resultant quality decease in the infection control program.

One other point consistently established at the hearings was that if there were any decrease in sanitation services, a great deal of this decrease would have to be absorbed by Nursing personnel. These personnel are trained to perform nursing functions, not environmental cleaning functions. They have been relieved of these duties progressively since 1954. Nurses are not trained to operate wall-washing machines, buffers, mops, environmental sanitation chemicals, wet vacuums, etc. As you know, the O. R. suite sanitation must be scrupulously maintained to prevent

cross infection. Until the early 70's, we had O. R. nurses at the D.C.V.A. Medical Center cleaning the operating suites after late emergency surgery. This proved to be a disaster, not because of the unwillingness of nurses to perform this function, but because they were not qualified to perform this function. For approximately 11 years at this facility nursing has not performed this function. It is my considered opinion that contracting out will be a backward step in the infection control process of approximately 10 years in many cases such as this.

There are cases, I am sure, where contracting out of sanitation services will result in some improvements. However, I firmly believe that application of A-76 to the housekeeping program of the VA will more often than not prove to be a liability to the infection control program. There are many questions which are unanswered in contracting out by private institutions. However, based on quality alone, these private institutions can and do revert back to in-house performance in many instances. A-76, based on cost economy alone, does not permit this. Infection control programs are not based on just economy. Sometimes, additional costs are incurred to reduce the risk of nosocomial infections. To subject the veteran patients to any diminution of services, especially where loss of life or undue suffering might result, is unacceptable to me and, I am sure, to all in positions of responsibility.

In summation, based on all that I have seen, read and know, I firmly believe that implementation of A-76 will prove detrimental to the infection control programs in VA Medical Centers. Implementation of A-76 should be avoided whenever infection control programs will be compromised. The Environmental Sanitation Program certainly fits this category.

RESPONSE BY NEIL MCBRIDE, CHIEF, ENGINEERING SERVICE, VETERANS' ADMINISTRATION MEDICAL CENTER, CLEVELAND, OHIO

Question 1. Are your people trained to repair more than one machine? For example, can VA employees repair the electrical and plumbing systems and perform the necessary maintenance of a dishwasher?

Answer. Yes. Our positions for equipment mechanics and general mechanics require the technical skill to repair a wide variety of equipment, e.g., dishwashers, industrial laundry equipment, conveyors, etc. However, when a problem is technically complex and specialized such as a breakdown in an electrical control system, an electrician or electronics mechanic is hired to support the repair work.

Question 2. If the Engineering Service is contracted out would it be fair to assume that you might have as many as three contracts for repair on one machine?

Answer. No. The statement of work would require the contractor to perform all the functions necessary to repair the equipment. Consequently, the contractor would be responsible for obtaining, perhaps subcontracting for, the special skills needed for equipment repair.

RESPONSE BY MARY HELEN MCGUIRE, CHIEF DIETETIC SERVICE, VETERANS' ADMINISTRATION MEDICAL CENTER

Question 1. In your capacity as Chief Dietician, have you discussed with other Hospital professionals the effect A-76 contracts may have on the integrity of the Dietetic Service? If so, what were the results of those discussions?

Answer. There have been many conversations over the past months with various members of the professional staff—Clinical Bed Chiefs, Nursing Service, Radiology, Chief of Staff, etc.—regarding the impact of A-76 on the nutritional care delivery to our patients.

The results of the conversations were unanimously critical of the concept of fragmenting Dietetic Service and the adverse effect on the nutritional care of the patients, the general opinion being Dietetic Service was just the beginning, that A-76 was an attack on the integrity of the VA Health Care System and a threat to the systems future. In other words, the beginning of chipping away, service by service, until the VA Health Care system no longer existed.

The attached memo, dated January 24, 1980, from the Chief, Medical Service states the concerns very well and indicates how long A-76 has been a worry to the professional staff. As recently as September 17, 1981, the Chief Medical Service discussed the adverse impact on the integrity of total patient care by the professional treatment team if the support services were contracted out at the Clinical Executive Board at this Medical Center. The minutes of this meeting include:

"Dr. Finkelstein proposed that the Clinical Executive Board go on record as being opposed to A-76. The committee concurred."

The Clinical Executive Board includes the professional staff of this Medical Center.

Attachment (1).

[Memorandum]

January 24, 1980.

To: Chief, Dietetic Service (120).
From: Chief, Medical Service (111).
Subject: Fragmentation of the Dietetic Program.

1. It is difficult for me to project the consequences of management of the food handling system by a private contractor external to Dietetic Service. My problem is simple—I cannot fragment into discrete functions an integrated system without knowing both the size of the pieces and who is going to pick them up. Consequently I would prefer to state my concept of the role of the total Nutrition Program.

2. In any hospital, Nutrition is of primary importance. Inappropriate food intake or assimilation underlies many diseases and is the consequence of numerous others. Unfortunately our recent survey demonstrated that this is a particular concern of the VA. It follows that we must evaluate the needs of every individual patient continuously during the period of hospitalization. Furthermore we must respond promptly (both diagnostically and therapeutically) to our findings. We must anticipate the predictable changes in each patient's needs which result from surgery, special testing, etc. Finally, we must prepare the patient and his/her family for the post-hospital period.

3. Implicit in the last paragraph is the necessity for a well-integrated, multidisciplinary program. I will not comment on the roles of physicians and nurses since that is beyond the context of the question. However, anyone familiar with a hospital knows that the physician and nurses respond primarily to referred patients with extreme nutritional problems. In turn this indicates the need for both a referral system and a means for managing the nutritional problems of the largest number of patients. It is obvious to me that these facets can be handled most professionally and efficiently by the combination of trained dieticians and sensitive, observant food service workers. The latter must be trained to note and report significant findings to the supervising dieticians. In this way every patient will be followed. An individual's failure to eat will not go unquestioned for an unacceptably long period of time.

4. In specific terms, we require the following functions from our total Dietetic Program.

(a) First evaluation of the needs of each patient with referral of extreme or otherwise defined cases to the Nutrition Team.

(b) Continuing education of ward staff including physicians and nurses to insure that each patient receives an appropriate diet.

(c) Constant monitoring of intake which may warrant detailed calorie counting.

(d) Provision of a wide spectrum of therapeutic diets which must allow individual modification of the content of salt, carbohydrate, fat, protein, lactose, calcium, gluten, etc. In addition, Dietetic Service must be responsible for special therapeutic preparations ranging from caloric supplements through tube feedings to elemental diets varying in compositon and/or concentration.

(e) Evaluation of the needs of the patient following discharge and acting to prepare the patient for this stage of his care.

(f) The interest and the willingness to participate in studies testing new therapeutic modalities as well as new systems of nutrient delivery.

There are several less significant functions. However, all share the same absolute requirement—we must have a program which allows immediate responses to a wide range of varying, individual needs.

5. In closing, I cannot resist the temptation to inject a note of caustic criticism. At a point in time when we are first defining the scope and importance of clinical nutrition it seems ludicrous that we (the VA) are considering the possibility of removing a key element from the total team. On the contrary we should be acting to integrate further the aspects of food technology and distribution. Without total (but reasonable) control of the entire nutrition process, I fear that our more ambitious efforts will fail. A new factor, potentially antithetical to patient care, will emerge—the needs of a group whose primary interest is neither the veteran patient nor the VA Medical Center.

JAMES D. FINKELSTEIN, M.D.

ENCLOSURE

Question 1. In your testimony before this Committee on October 20th, you indicated that the Administrator of Veterans Affairs has wide discretionary latitude in

applying your definition of "government commercial-industrial product or service" to the activities of the Department of Medicine and Surgery. You seemingly suggested he may unilaterally determine a given "in-house" function to be inherently Governmental. The VA witness testified that the Administrator has no such authority under A–76, at least as interpreted by the VA. Please provide the Committee a full explanation of that authority and cite the paragraph(s) within OMB circular A–76, or other executive authorities, which authorize such agency discretionary decisions of defining "commercial/industrial products and services."

Answer. Paragraph 3 of the Circular states that each agency head has the responsibility to ensure that the provisions of the Circular are followed. Paragraph 5.a defines Government commercial or industrial activites. Paragraph 5.f defines Governmental functions. Paragraph 6.b states that Government functions must be performed in-house. Paragraph 6.d(7) states that the Circular should not be applied when it would be contrary to law. Paragraph 10 describes agency actions required to administer the policy including implementation actions, creation of inventories of commercial or industrial activities, and scheduling and conducting reviews.

The Circular leaves it to the agency head to define which agency activities are subject to the Circular's provisions. In doing this, any activities that meet the test of a Governmental function cannot be considered for possible contracting. Likewise, any activity precluded by law from contracting must also be excluded from consideration. Any remaining regularly needed activities are subject to the Circular and may be authorized for in-house Government operation only when there is no satisfactory commercial source available, the activity must be operated by military personnel for the specific reasons stated in the Circular, or a private commercial source is proven to be more expensive.

Question 2. The Honorable Patricia Schroeder of Colorado submitted a formal statement to the Veteran's Affairs Oversight and Investigations Subcommittee at its July 14th hearing on OMB Circular A–76. On page 146 of the Subcommittee's official record of that hearing, Ms. Schroeder indicated that the U.S. Army's health Services Command has commissioned a study of the escalation of contract costs in military facilities. Please obtain and provide the Committee a copy of that study, with your analysis of the study's finding and conclusions.

Answer. Inquiry of the Army has failed to disclose the existency of the cited study. However, a recent study by the Defense Audit Service addressed the question of cost growth in service contracts. This study concluded that based on their review, there was no evidence of contractor buy-ins nor unusual cost growth. A copy of the study is attached.

Question 3. Early in 1981 OMB subjected the Department of Medicine and Surgery (DM&S) to a Presidentially-directed Federal employment hiring freeze. "Direct medical care," defined by OMB as essentially physicians and nurses, was exempted from the hiring limitations imposed on departmental employment. You testified on October 20th berfore this Committee that the "direct medical care" mandate of Title 38, United States Code, would be respected as regards A–76 applications in the DM&S. Please provide to the Committee a comprehensive, categorical listing of "direct medical care" functions which Title 38 exempts, but which otherwise would require comparative cost review under OMB Circular A–76.

Answer. As indicated in the answer to the first question, the Circular leaves it to the agency head to determine when certain activities would be precluded by law from application of the Circular's provisions. We believe that the VA General Counsel's opinion establishes clear parameters for making these determinations within the VA and the activities currently included in the VA's inventory of commercial and industrial activities appear to be fuly in keeping with that opinion.

Question 4. In your October 20th testimony, you testified that twelve military hospitals have awarded A–76 contracts for hospital food services. For the record, please identify those facilities for the committee, as well as the names of the contract firms. In each case, please provide the contract prices versus the in-house cost estimate, and indicate whether the contracts include or exclude food service in the preparation of special diets. In those contracts which do include special diets, please indicate the percentage comprised of special diets versus other hospital food service. The Committee also wises to know for all twelve contracts, if any of the food service contractors have established vending areas, snack bars for other outpatients, visitors, or employees.

Answer. As we stated in our testimony, the food service function for twelve Air Force base hospitals is not being accomplished by personnel integral to the hospital operation. At these installations the food is prepared by the base dining hall and transported to the hospital. The operation of the dining hall is a combination of Air Force cooks and contractor food service attendants. There is no separate contract price associated with preparing food for the hospital. Whatever special diets are

required are prepared by the base dining hall. There is no feeding in the hospitals for personnal other than patients. Our reason for citing these hospitals as an example is that we believe preparation of patient food can be accomplished without the source of preparation being under the direct control of hospital management. In addition the Navy has food service contracts in the following hospitals: Naval Aerospace and Regional Medical Center, Pensacola, Florida; National Naval Medical Center, Bethesda, Maryland;[1] and Naval Regional Medical Center, Camp Lejeune.[1]

The Air Force hospitals where this mode of operation is in effect are: Blytheville AFB, Arkansas; Castle AFB, California; F. E. Warren AFB, Wyoming; Grand Forks AFB, North Dakota; Griffiss AFB, New York; K. I. Sawyer AFB, Michigan; Loring AFB, Maine; Molstron AFB, Montana; McConnell AFB, Kansas; Plattsburg AFB, New York; Whiteman AFB, Missouri; and Wurtsmith AFB, Michigan.

In addition, the Navy is presently conducting cost comparison studies on their hospital food service operations at the following locations: Pendelton, Long Beach, San Diego, Port Hueneme, Jacksonville, Orlando, Great Lakes, Camp LeJeune, Philadelphia, Newport, Charleston, Memphis, Corpus Christi, Portsmouth, and National Naval Medical Center.

Question 5. In your verbal testimony on October 20th, you indicated A-76 contractors must meet veterans' preference requirements in their employment practices. It is the Committee's understanding that contractors must meet only the requirements of FPR Temporary Regulation 39, which are exceptionally weak in comparison with the mandatory requirements for direct federal hiring. The Committee believes this inequity may subvert the intent of Congress in regard to Federal advocacy for Veterans' employment. Please provide the Committee a report comparing the two (regulation 39 versus Federal Veterans' preference). Also, please provide the Committee your views on why the executive branch cannot apply absolute Veterans' preference requirements to contractors, similarly to the manner in which privacy requirements are applied to contractors.

Answer. FPR Temporary Regulation 39 has its basis in the Vietnam Era Veterans' Readjustment Assistance Act of 1972. In general, it requires contractors with contracts in excess of $10,000 to take affirmative action in employing veterans, precludes discrimination, and requires listing of openings with local employment offices. In this respect the requirements are roughly similar to those placed on the Federal Government as an employer. However, the FPR does not mandate any specific features of a contractor's affirmative action program. We were unable to discover any data that would allow us to directly compare the results of private sector programs to those of the Federal Government.

While the FPR does not mandate any specific contractor hiring practices, OMB Circular A-76 does. Paragraph 10 of the Circular requires agencies to include a provision in the contract that gives Federal employees displaced as a result of conversion to contract performance, the right of first refusal for employment openings on the contract in positions for which they are qualified.

We believe that the veterans preference clause in Federal contracts, when taken in conjunction with other contract caluses relating to equal employment opprotunity and hiring the handicapped, and the unique Circular A-76 clause giving displaced employees the right of first refuasl offer a very favorable employment opportunity for veterans. The net effect of the right of first refusal clause for procurements related to Circular A-76 cost studies is to give absolute hiring preference to qualified displaced Federal employees that are veterans thus, we do not believe any further action is necessary to enhance their employment opportunity under contracts.

Question 6. On pages 63 and 64 of the official record of the July 14th hearing, you indicated a 60-percent savings was realized in the Keesler AFB hospital custodial service contract. You also stated that DOD does not use military personnel costs as a factor in its A-76 cost comparisons. In the Keesler study there was a difference of more than $2 million between the in-house estimate and the winning contract bid. The Committee finds it incredulous that this cost difference could have been valid, especially in that the in-house estimate should have reflected the most economic arrangement possible (as required by the A-76 Circular.). Please provide the Committee the following information about the Keesler study.

a. How many military and civilian personnel were working in this custodial/housekeeping program prior to the study?

b. How many military and civilian personnel work in this function at this time?

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[1] Part of the food service function is under contract and the remainder is undergoing a cost study in fiscal year 1982.

c. In its cost comparison "bid," how many civilian personnel did DOD propose to be necessary for the in-house function? What was the average salary for such proposed personnel?

d. How many contract workers are currently employed on this contract? What is the average salary of each study worker?

Answer. Following are answers to your specific questions.

a. Data maintained by the Department of Defense shows that on July 1, 1979, 55 persons were authorized to perform housekeeping services. Due to planned increases in areas to be maintained and changes in the types of floors to be cleaned the level of manning is variable and would have been 61 on August 1, 1979, 58 on September 1, 1979, and 66 on January 1, 1980.

b. In view of the fact that the function was converted to contract, no military or civilian personnel are assigned to the activity of hospital housekeeping.

c. Based on the requirements of the statement of work, known changes, and the staffing profile chosen, 64 staff years of effort were costed. The average salary for the proposed personnel was $210.30 per week.

d. The contract for housekeeping services at Keesler AFB was awarded using formal advertising procedures and resulted in a firm fixed price contract. The statement of work does not specify a set level of manning but rather sets specific performance parameters that must be met. As a consequence, no contractual records are kept on the number of personnel employed by the contractor or their salary levels. Communication with local official indicates, however, that the contractor has about 55 employees. These employees are paid at least the minimum wage established by the Service Contract Act wage determination contained in the contract.

Question 7. The Committee assumes that a substantial number of DOD A-76 contracts were set-aside for small and minority businesses. For those contracts in DOD awarded since October 1, 1979, please indicate the number of set-asides. Among the set-aside group, please indicate the number of defaults and cite the nature of the service which had been provided.

Answer. Contacts with the Office of the Secretary of Defense and the military services indicate that they do not maintain summary statistics relating to small business awards incident to Circular A-76 cost studies. However, they did state that, with the exception of the Army which studies larger activities such as whole installation support functions, the majority of awards are made on a set-aside basis. No formal statistics are kept on the incidence of default in contracts resulting from Circular A-76 conversions in DOD. However, to their knowledge, only a very small number occurred and when default did happen, contingency planning precluded any loss of service.

Question 8. For the twelve A-76 hospital food service contracts DOD has awarded so far (as indicated in your testimony), please provide the Committee the number of "quality assurance evaluators," including both military and civilian personnel, who monitor each such contract. Please indicate the total amount of their annual salaries and fringe benefits, including the civilian and military personnel.

Answer. As stated in our answer to Question 4, the food service operations are not specifically for the hospital and the contractor has only limited involvement in preparing and cooking, and none in transporting or serving patient meals. Thus, no inspection costs are directly attributable to hospital food service.

Question 9. For A-76 prompted conversions, did OMB consider the total cost to the government to carry out reduction-in-force procedures, particularly in such labor intensive activities as VA's Department of Medicine and Surgery? The Committee especially wishes OMB's answer in light of retraining and relocation expenses and severance pay for several thousand displaced VA employees.

Answer. The cost comparison procedures of Circular A-76 require consideration of one-time conversion costs and specifically mentions retraining, relocation, and severance pay expenses. These costs are estimated and charged to the cost of contracting-out before it is compared to the cost of in-house operation.

Question 10. The Committee believes the cost to the government to conduct A-76 studies to be exorbitant. To what extent did OMB consider this "hidden" cost informulating the "contracting out" policy? The Committee strongly believes that such efforts must be considered as a cost within the cost comparison study itself. Does OMB have any plans to adjust the cost comparison procedure to account for this "hidden" cost?

Answer. We believe that the Veterans Administration estimates for doing the cost studies are extremely high and that they have not taken the available opportunity to group similar or related functions into a single study. Using the VA's estimating factor of 3.5 man-months per study at an average cost of $7,500, we believe that all of their studies could be done for a onetime cost of less than $10 million. When

compared to estimated potential savings we believe that each dollar spent on studies will return a savings, to the government of more than 10 times that amount.

We do not believe that these costs are properly chargeable to the cost study effort. By law agency heads are charged with the fiduciary responsibility of meeting their agency mission in the most economical manner. The pursuit of this objective should involve a constant search for more most effective options for providing authorized levels of service. Circular A-76 simply prescribes a formal, structured approach to meeting this fiduciary and management mandate. Thus, we believe cost studies to be a normal management practice and not a unique undertaking that should be treated as a one-time conversion cost.

Question 11. In answer to a question whether OMB thought Circular A-76 would be used to contract out for the entire service or for employing someone to manage the VA staff, you responded, "No sir, I don't believe that is the case of Circular A-76 at all. The idea—in fact, I think it would be illegal to have a contractor come in and manage Government employees." However, in your opening statement you discuss the private sector's use of contract services in the health care arena. You allude to a July 1981 periodical entitled "Modern Health Care" in which you state "there is a rather enlightening article on the subject entitled "Contract Management Survey'." The Committee is familiar with the article and knows it to deal with contract management rather than contract services. Can you explain this discrepancy between your prepared remarks and your answer to the question? Also, is OMB going to reconsider the Circular to augment contracting out for management teams?

Answer. We do not agree that there was a discrepancy between our prepared testimony and subsequent oral remarks. The statistics in the article are summary in nature and contain data relating to full service contracts as well as management only contracts. However, in either case a contractor has management responsibility for the activity. As stated in paragraph 6.d of Circular A-76, its authority cannot be used to enter into management only contracts since this would amount to establishing an employer-employee relationship.

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